

A STUDY OF CARING WITHIN AN INSTITUTIONAL  
CULTURE

by

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THE UNIVERSITY OF UTAH GRADUATE SCHOOL

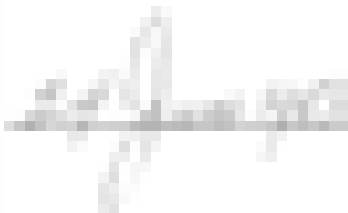
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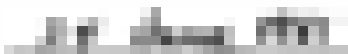
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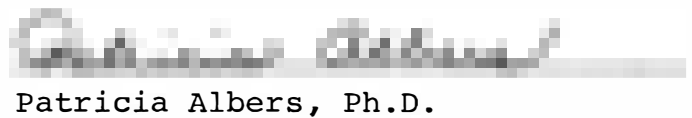
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## ABSTRACT

Caring is central to the profession of nursing, and cross-cultural caring is central to the sub-field of transcultural nursing. This study is an analysis of the meaning of caring expressions and behavior, principally those which are related to nurses within a hospital culture in the United States. Caring was investigated by primarily an inductive research approach through participant observation techniques. Comparative data of different social units (persons, roles, clinical units, and documents) formed the basis from which conceptual categories of caring (a classification system), and theoretical frames of reference were discovered.

A classification system founded on 1362 caring responses of 192 participants consisting of four categories with their respective subsets was developed. They are as follows: Psychological (Cognitive and Affective); Interactional (Social and Physical); Practical (Technical and Social Organization); and Philosophical (Spiritual, Ethical, and Cultural). The Psychological category received the largest number of responses,

followed by the Practical, the Interactional, and lastly, the Philosophical categories. The classification system reflected the current shift from humanistic-religious dimensions of caring to practical dimensions influenced by the relationship of caring to the bureaucratic dominant American social structures.

In an analysis of caring within the hospital clinical units, data reinforced the existence of a logical connection between caring behaviors and the bureaucratic social structure. Contrasting examples of differential caring patterns emerged. A substantive theoretical frame of reference of differential caring was identified. The pattern of differential caring, coupled with the patterns discovered in the cognitive analysis were abstracted into a formal theoretical frame of reference, bureaucratized caring.

The theoretical frames of reference of differentiation and bureaucratization demonstrated the complex meaning and structure of caring in a contemporary hospital culture. Ideal nursing models of caring were replaced by a bureaucratic model which produced professional conflict for the majority of nurses. The future of nursing now depends on how well the nature of bureaucratic caring is understood. To help in the development of transcultural nursing awareness and caring knowledge,

a list of recommendations for research, education, and practice was suggested.

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## CHAPTER I

### INTRODUCTION

Nursing in the western world, and especially, nursing within western cultural institutions, such as hospitals, has struggled with the dilemma of whether or not its major contribution as a profession is related to caring or curing. This dilemma is reflected in the modern history of nursing, and is one of the fundamental issues which nursing must resolve if the profession is to become more viable. On the one hand, the contemporary academic and/or theoretical literature has revealed the strong ideological position of caring while, on the other hand, the literature of hospitals has revealed data about increasing conflicts in the operationalization of caring beliefs. Leininger (1977a; 1978) claimed that caring is the essence of nursing, however, most nurses within hospitals have adopted or adapted to following the curing model of the medical profession as their practice behavior (see Appendix A for working definitions of caring and curing). Leininger noted, however, that nurses have not pursued a systematic investigation of the

linguistic, cultural, cross-cultural, and psychosocial impact of care behaviors and processes to know the extent to which care is an essential component of professional nurses' work. Furthermore, Leininger remarked that the concept of care is one of the least understood ideas used by professional and non-professional people; yet it is probably one of the most important concepts to be understood by human groups (Watson, 1979). Nursing, therefore, must begin to describe, interpret, analyze, and clarify the multiple meanings and functions related to various professional cultural values and behaviors of care and caring. The study of contemporary American professional caring is the key to understanding the direction and scope of the subfield of transcultural nursing by providing the fundamental knowledge from which cross-cultural comparisons of caring data can be made.

### Purpose and the Conceptual

#### Framework

The purpose of a study of caring phenomena (values and behavior) within an institutional context was to utilize the basic tenets of transcultural nursing outlined by Leininger (1978) -- comparison and analysis of caring to develop an humanistic and scientific body of knowledge. The research deviated from Leininger's specific theoretical framework by the choice of primarily inductive

research methods rather than the generation and testing of specific hypotheses in the study of institutional caring.

Two overarching directives were developed as part of the researcher's inductive method: research questions and objectives.

### Research Questions

The following research questions were used as a guideline in the process of participant observation to elicit caring data.

1. What are the expressed cultural caring values, beliefs and attitudes of different groups within the hospital: administrators; nurse-administrators; nurses (registered nurses and licensed practical nurses) auxillary personnel (nurses aides, orderlies); clients; support personnel and physicians?
2. How are caring behaviors manifested within various clinical nursing units within the hospital?
3. Are there different classifications of care/caring within an institution? If so, what are they?
4. Can clear distinctions be drawn between caring and/or curing phenomena within the hospital community, and/or the profession of nursing?
5. Can a theory of institutional caring be formulated?

The study was organized in two phases. Phase I was an investigation into the values of administrative personnel, and Phase II was an investigation into caring



values and behaviors within each clinical nursing unit.

### Objectives of the Study

The following objectives served as the second directive to the inductive research method:

1. To compare social units within the institution (roles, groups, and philosophies) to develop a structural framework or categories and properties of caring.
2. To identify the influence of the social structural characteristics of a complex organization on values and behavior.
3. To understand the intra-inter-professional communication patterns of groups which influence caring behavior.
4. To recognize and describe caring processes and patterns which have a bearing on health-illness outcomes of clients.

### Rationale

The rationale for conducting transcultural nursing care research in an institutional environment in the mid-western region of the United States, rather than selecting culture group(s) from different countries, was multidimensional. The investigator believed first of all that caring phenomena of nurses within this country has not been studied adequately. Definitions, meanings, and classification of care in conjunction with descriptive theory would provide:

1. An understanding of the underlying general thesis of institutional nursing care;

2. Clearer distinctions between the notions of caring and curing within the social-cultural context of the hospital;
3. A determination of whether or not caring is indeed the essence of nursing within an institution;
4. Distinctions between direct and indirect care;
5. How care is perceived by nurses, clients, administrators;
6. Caring classifications -- for example, "Is there a caring classification called technological care/caring?";
7. An understanding of the social-cultural milieu of a bureaucratic institution on the behavior of nurses;
8. A description of the prevailing ideologies of a complex institution;
9. The knowledge of how different cultural groups perceive professional care;
10. The identification of changing ideologies of nurses within a contemporary American institutional culture, and
11. Data from which national and international cross-cultural caring comparisons can be made.

Secondly, nursing care behavior within American culture is a transcultural phenomenon given the nature of the definition of Transcultural nursing (see Appendix A), and the following assumptions postulated by Leininger (1978):

1. Nursing is essentially a transcultural phenomenon in that the context and process of helping people involves at least two persons generally having different cultural orientation or intracultural life styles [assuming cultural

differences between the nurse and client].

2. Transcultural nursing care behaviors, processes, forms, values, and beliefs have yet to be explicated in a systematic scientific way with thought to the humanistic bases of care giving and care receiving.

3. What constitutes efficacious or therapeutic nursing care is largely "culturally determined, culturally based, and can be culturally validated" [assuming that a hospital is an institutional culture].

4. The essence of nursing is "caring"; and the essence of transcultural nursing is caring for people of diverse cultural backgrounds.

5. Transcultural nursing activities, functions, and processes will vary with the social structure and cultural system of a designated culture and in relation to acculturation, to culture contacts, and culture history [assuming again the nature of the hospital as an institutional culture; and the nature of nursing as a professional culture] (pp. 35-36).

### Transcultural Nursing

The development of the interrelationships between the fields of nursing and anthropology have been advanced by Leininger, Aamodt, Byerly, Brink, Horn, Glittenberg, Osborne, and others. Leininger (1978), however, coined the phrase "transcultural nursing", and described it in the following way:

Transcultural nursing is the subfield of nursing which focuses upon a comparative study and analysis of different cultures and subcultures in the world with respect to their caring behavior; nursing care; and health-illness values, beliefs, and patterns of behavior with the goal of developing a scientific and humanistic body of knowledge in order to provide culture-specific and culture-universal nursing care practices (p. 8).

The "culture" concept is basic to understanding the

significance of transcultural nursing. Spradley and McCurdy (1975) have emphasized the cognitive dimension of experience by interpreting culture as "the acquired knowledge that people use to interpret experience and to generate social behavior" (p.5). Honigman (Leininger, 1978) has defined culture as patterns of learned behaviors and values which are shared among members of a designated group and are usually transmitted to others of their group through time (p. 60). Culture, consequently, becomes a vital element in determining caring values and social behavior. Important to a study of this nature is the interpretation of the institution as a culture wherein patterns of values and behaviors are transmitted amongst particular groups who are members of the institutional culture.

Embedded in the definition of culture is the concept of "values" which according to Kluckhohn (1951) are ideas formulating action commitments. Kluckhohn has discussed the fact that ideas are instigators of behavior within the individual, and although values and motivation are linked, they rarely coincide completely.

The culture of nursing has value orientations based upon historical and traditional factors as well as current, modern points of view. The discovery of the meaning of those values is vital to understanding the

decisions and actions necessary to shape the future of contemporary nursing, and to provide the necessary knowledge for the growth of transcultural nursing.

The Concept of Care/Caring and the  
Functional Role of Caring and  
Ideologies in Nursing

Before exploring the concept of care/caring, a review of the multiple definitions listed in the Oxford English Dictionary Volume II-C (1933; Reprinted 1961, pp. 115-116) are as follows:

Care (Noun) 1. Mental suffering, sorrow, grief, trouble. 2. Burdened state of mind arising from fear, doubt or concern about anything, solitude, anxiety, mental perturbation. 3. Serious or grave mental attention; the charging of the mind with anything; concern, heed; heedfulness, attention, regard; caution, pains. 4. Charge; oversight with a view to protection, preservation or guidance. 5. An object or matter of care, concern, or solicitude.

Care (Verb) 1. To sorrow or grieve; to mourn, lament. 2. a) to be troubled, uneasy or anxious. b) to feel concern (great or little), be concerned, trouble oneself, feel interest. c) to be careful, to take care. 3. To care for: to take thought for, provide for, look after, take care of. 4. In negative and conditional construction: a) not to care passes from the notion "not to trouble oneself," to those of not to mind, not to regard or pay any deference or attention, to pay no respect, be indifferent. 5. To have a regard or liking for a) to be inclined or disposed to, to think it worthwhile to do. b) to have regard, fondness or attachment for. 6. To regard a) to take care of, preserve with care.

Linguistic meanings of the dictionary definitions

for both the noun and the verb "care" are represented by ideas revolving around sorrow and suffering. Not one of the definitions referred specifically to the concept of helping, or stimulating growth; however, notions of provision, concern, protection, preservation, and guidance are helping and supportive concepts.

The dictionary analysis of the term "care" also connotes meanings related to the concept of compassion.

What "care" evokes in this sense has its roots in the Latin verb "campatio," which means to suffer with.

Nouwen (1977) explained compassion as the following:

. . .the deeply felt awareness of oneness of the human race, and the fact that all people are bound together by the human condition.  
(p. 15)

Caring in relation to aspects of the human condition will be traced briefly from the time of early man through religion, through Christian history and finally how caring was and is depicted in nursing. Although the human condition has been interwoven with acts of neglect and hatred, positive caring notions will be emphasized in this conceptual analysis.

### Caring and Early Man

Ralph Solecki (1971; Constable, 1973), an archaeologist, elucidated the nature and behavior of Neanderthal man who emerged in Europe during the Middle

Paleolithic archeological period (middle period of the Old Stone Age) about 40 to 100 thousand years ago. Rather than the usual image of Neanderthal man as a shuffling beast, Solecki's picture depicted him as the mind of modern man locked into the body of an archaic creature. The basis for these views came from the discoveries of Neanderthal's beliefs, customs, and rituals. Solecki (Constable, 1973) explained that burial of the dead, compassion for fellowmen and attempts to control destiny were aspects of Neanderthal life. He stated that "they cared, a human phenomenon totally fresh in the emergence of man" (p. 7). Furthermore, Solecki (Constable, 1973) emphasized that:

If there is anything that can be labeled as of paramount importance in human development, aside from the evolution of the brain itself, it is the appearance of caring (p. 7).

Solecki (Constable, 1973) also demonstrated that Neanderthals were concerned for the handicapped. For example, in a study of fossil remains at his "dig" site in Shanidar in northern Iraq, Solecki found skeletal remains which revealed that a Neanderthal, 40 years of age, had had the use of only one arm. Despite his disability, he lived a long life for a Neanderthal, which suggested that he had to be "cared for" by his kin.

Although Solecki claimed that caring emerged only 40-100 thousand years ago, caring, must have been present

in maternal-child behaviors of other early women (and men) and animals. Leininger (Watson, 1979) stated that from a nursing and anthropological viewpoint, the idea of care for self and others is one of the oldest forms of human expression. She remarked that "since the beginning of mankind, care appears to be the critical factor in bringing newborns into existence, stimulating individual growth, and in helping people to survive stressful experiences" (pp. xi - xii). Thus, caring as nurturant behavior has been present throughout history.

#### Caring Through Religion

Religion was and continues to be an important element in caring processes, and many roots of care behavior can be found in interpretations of primitive religion and practices (including witchcraft and magic); and in the sacred writings of the mystical religions (Confucianism, Taoism, Hinduism, Buddhism), and the prophetic religions (Judaism, Christianity and Islam).

In the study of many ancient religions, Griffin and Griffin (1973) noted that priestesses were described as performing certain functions, such as midwifery and child care activities now recognized as belonging to nursing. Also, in early cultures and existent today, are many health practices which use elements of religion and magic in processes of caring and curing. Foster and Anderson



(1978) remarked that "primitive medicine" (folk practices and curing processes) became one of the foundational sources of medical anthropology. Current transcultural nursing writings have emphasized the relationship of folk practices, and caring which have begun to provide the basis for understanding culture-specific care decisions between nurses and clients. They are fundamental to cross-cultural caring comparative knowledge.

Caring has been exemplified in the literature and activities of the prophetic and mystical religions although interpretations vary. Kung (1976) reported that all world religions perceive the goodness, mercy, and graciousness of Divinity, and heed the call of their prophets or traditions who or which are models of knowledge and behavior toward greater truth and deeper understanding of life and one's fellow man/woman.

#### Caring Through Christian History

Although Christian history is fraught with periods of violence and war the ideals of brotherhood, service, charity and self-sacrifice were promoted by the early Christian church. Griffin and Griffin (1973) remarked that at this time, groups whose main function was to care for the sick and needy developed and became organized as groups of deacons and deaconesses. During 1000 years of Christianity there were no attempts to organize

nursing as a separate vocation. However, during the Middle Ages, three organizations developed which have persisted to the present and have established principles recognized as important for the development of professional nursing -- the military, religious orders, and secular groups. Religious and secular groups worked under the auspices of the church, which profoundly influenced activities of the Middle Ages. During the period from the end of the seventeenth to the middle of the nineteenth Century, medicine was becoming a science, by principles established by Harvey, Sydenham, and others. These new modes of thought, however, did not guide patterns of ecclesiastic nursing. During and after the period of the Reformation, "caring activities", deprived of their sanction within the Catholic church, lost social standing. People involved in caring contexts were recruited from the lower stratum of society, and caring for the sick increasingly became a domestic service. "Nursing" persisted under dire conditions until the time of its formal development by Florence Nightingale, who initiated an organized, a secular vocation which required technical skills, intelligence, and moral purpose (Griffin & Griffin, 1973).

Caring in Nursing: The  
Development of Professionalism

Nightingale (1964), called the "mother of modern nursing", emphasized that professional nursing was, not only, caring for the sick, but also, to be health oriented -- nursing was to put people in the best conditions for "nature" to restore or preserve health and to prevent or cure disease and injury. According to Nightingale, nursing, although signified as little more than the administration of medicines and the application of poultices in her time, ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet -- all at the least expense of power to the patient. Nightingale pointed out that the health of "houses" depended upon pure air, pure water, efficient drainage, cleanliness, and light. Unhealthiness resulted in proportion to the deficiencies of these factors. Nightingale also emphasized "good nursing" as management. She advocated the use of the delegation of responsibility. Nightingale noted that the environmental and organizational processes enabled the nurse to set forth the principles of restoration. She remarked that it is "Nature" that cures, not the physician or the nurse!

In the tradition of organized caring activities Nightingale (1964; & Seymer, 1954) pointed to nursing as the art of charity, "God's work," as she expressed it.

To raise nursing from its domestic position, Nightingale restored it to its ecclesiastic state by claiming that the nurse was of the highest class of character, and was to be in herself -- honest, truthful, trustworthy, hopeful, orderly, and thinking of others rather than herself as well as tender, cheerful, kind, patient and ingenious.

In relation to medicine, Nightingale said nursing, performed usually by women, was under scientific heads -- physicians and surgeons. Accordingly, she said nursing was to put people in the best possible conditions for "nature" to restore and preserve health -- to prevent or cure disease or injury. She supported the fact that the physician or surgeon prescribed these conditions, and the nurse carried them out.

This account of Nightingale's beliefs regarding nursing elucidated her astuteness and knowledge of the environmental impact on health care, the emphasis of nursing on prevention, and the emphasis of nursing management on patients, humanistic/religious attributes, and the role which nurses assumed with respect to physicians. Much of her knowledge was the result of her military nursing in the Crimea beginning in 1854. Nightingale's professional program reflected these ideas by the subjugation of nurses to stringent conditions of militarism, obedience, and duty to authority. Her influences and

contributions to the development of English nursing spread worldwide where the Nightingale plan of "nurse training" began to be established.

Although Nightingale divided nursing into four categories -- three of which were oriented to community nursing -- private nursing, district nursing, and nurse-midwifery -- the hospital model became the chief one adopted initially by nursing (actually by medicine, in the United States, which will be illustrated later). The stringent principles of militarism and obedience to authority were reflected in how nursing was to be practiced. Its impact was felt in Nightingale's time, but it exists to a large extent in today's nursing. On the one hand, Nightingale idealized a nursing "theory" of environmental and preventive health. On the other hand, by her principles of obedience and subservience, Nightingale's model of nursing practices gave preference to the physicians and surgeons as the ultimate authority. Even from the early history of modern nursing, care for prevention and the "health-oriented" model were replaced by ideas and ideals prescribed by physicians in highly structured bureaucratic systems. As a result, the "curing" model of medicine and the organizational model of hospitals, once firmly established, have lingered and survived.

Of historical significance in the United States is the description of the development of nursing -- hospital nursing, specifically. Richards (1901) explained that in September of 1872 in Boston, the first class of nurses in America was organized and admitted to a New England hospital for training under the direction of a female physician, Dr. Dimock, who had taken special pains to learn "nursing" while in Germany. Dock (1901) explained also that a physician, Dr. Wylie, visited England and the Continent to study the system of nursing in 1871 in order to initiate its development at Bellevue Hospital in New York. These historical works illustrated the origin of nursing in the United States. Clearly, nursing in hospitals was first organized by physicians. Moreover, the curriculum of the first nursing school was based upon the classifications in medicine -- for example, surgical, medical, obstetrical, and pediatric nursing. This practice, for the most part, has held true in many diploma nursing programs today; and the American Nurses Association still classifies the majority of its specialty areas under these classifications.

To "carry out" physicians' orders became, and continues as a major component of nursing care. Although "caring" was directed to the patients, "caring for" the physician by exclusive attention to "orders" left the

nurse subservient and a "handmaiden" to the physician. It is not surprising that serious conflicts have resulted in the nursing profession. The ideology of caring did not have a chance to evolve successfully. First of all, "professional" nursing in the United States was conceived of and nurtured by physicians; secondly, "trained" nursing education was conducted in hospitals; thirdly, "trained" nursing was organized according to a medical model -- that is, medical, surgical, obstetrical, and pediatric divisions; fourthly, "carrying out" physicians' orders became the primary function of hospital nursing; and fifthly, hospitals were organized according to an hierarchical system of management with physicians taking their place at the top (although not hospital employees). Thus, these problems have resulted in the conflict between a nursing value system, loosely committed to care, and strongly operationalized from the value structure of organizations and physicians.

"Caring" issues at the turn of the century focused upon organizational and legal concerns and the development of public health nursing. As has been noted, hospital nursing was built upon the intervention and control of physicians. In contrast, Lillian Wald, the developer of the New York Henry Street Settlement, demonstrated that nursing could initiate and govern its own

professional actions, and caring responsibilities with independence, dedication, pride, and notable service to citizens. Nurses, by virtue of their independent actions, were able to influence public officials to create lasting social and health benefits for residents. Unfortunately, today the great independent talent manifested here is only partially witnessed in the public health sector and is virtually absent in hospital nursing.

The historic period from 1914 to 1930 brought increased changes and insight into the lives of nurses. Although the suffragette struggle was alive within women, there continued to be hospital control over nursing education; and male militarism impeded the struggle for nursing autonomy. Dedication to the patient via dedication to the "orders" of physicians continued to dominate. In fact, most of the military nursing during World War I concentrated on the development of wound infection and upper respiratory "curing" skills as a mode of nursing care. The control of nurses by physicians and others, especially males, centered not only in hospitals but also in the military system.

Nutting emphasized two separate functions for nursing in 1926 -- one for education and one for the care of the sick rather than both education and practice in the hospital. It did not take hold. Therefore, the issue



of "care" remained under the control of hospitals, and physicians as well as nurses were successful in promoting the continued development of the nurses' "curing" role. These ideas progressed through the depression period from 1930-1939.

During World War II, and immediately following the war, there was much soul searching in nursing. The war years exposed the nurse to the public. She was considered a "savior" in many situations overseas. Medical diagnosis and the independent decision-making position of nurses were enhanced. The war left a shortage of nurses in hospitals in the United States; thus, practical or vocational nursing originated. Nursing responsibilities, especially at the bedside, were taken over by the less-prepared nurse under the supervision of students or registered nurses.

The development of "new roles" in the nursing ranks led to more discussion and research into nursing education, and Montag's (1951) proposal was designed to create the "technical" nurse to fulfill shortages of "hospital" nursing needs. From that point, the distinction between technical and professional nursing (and caring) became a dilemma. For nearly thirty years this new conflict of technical and professional nursing has created a marked division in the profession. The Brown Report of 1948

failed to accomplish its recommended goals which was to develop substantially more four-year professional nursing university programs at the same time the two-year community college programs went into existence. Consequently, both technical and professional nursing were not sufficiently distinguished or differentiated. As a result, the dilemmas which continue to face nursing are the following: the failure to close three-year diploma schools, the increased development of practical nursing programs, the name "technical" nurse, the functions and roles in the actual practice of nursing, the differentiation between technical and professional caring responsibilities; examination and licensure as registered "technical" nurse versus registered professional nurses; salary and employment benefit differentials, hours of working responsibilities, articulation of differences with other health professionals, career mobility, specialization, and emotionalism about who is, what is, how is one a "true" nurse. With the mushrooming of associate degree programs, graduating registered "technical" nurses, are hired by hospital bureaucracies at increasing rates to assume any or all types of nursing responsibilities. By 1985, it is proposed that the two forms of nurses must be differentiated. In this dilemma nurses working in hospitals with associate degrees have suffered because of the

increased strain placed on them. They are expected by administrators of hospitals to function "professionally" in the decision-making roles of expert practitioner and manager when they are prepared as technicians. Thus, confusion in the roles of nursing and its functions have been enhanced by education changes rather than diminished!

The historic period of 1952-1961 was ushered in with the advent of the official establishment of nursing research. Nursing research has revolved around certain investigations and discoveries in science and those problems associated with nursing service and education. Since conflicts between the roles and practices of nursing began early in American nursing, it is not surprising that much of the research centered around those problems. Although research has been accomplished in those areas, dissemination and implementation is not fully realized. The factor of control by institutional administrators and physicians, economic restrictions, and professional political decisions have mitigated against satisfactory implementation of the research results in the practice of nursing.

A great concern also at that time was the "role" of the nurse. Sociologists, such as Saunders (1954), attempted to analyze the external behaviors of nursing in

relation to the prevailing value of nursing, that is, the care and welfare of the individual patient. Individualized care, however, was predicated on "team" nursing beliefs. To fulfill the needs of the whole patient, team nursing fell short of its goal by fragmenting care in parts and segments. Professional nursing understood exclusively as the coordination of care did not serve to answer the question of what the true role of nursing was and what constituted nursing. Kreuter (1957) attempted to give clearer distinctions between care and cure. She specifically stated that care was not akin to cure. On the one hand, Kreuter explained care as a feeling experienced and responded to by the extension of one's self to another. On the other hand, she said cure activities were related to the administration of medications, tests, or treatments, or assisting with their administration. She remarked that assisting the doctor, rather than the patient, was solely facilitating a medical-technical operation.

From 1961 to 1970, this period in nursing history represented some similar and different views. The similar view revolved around the dilemmas in education and service, while the different view was the incorporation of the cultural components of individuals and groups into nursing education and practice.

This period was especially characterized by the "infamous" position paper (1965) on education and nursing, which clearly stated that the baccalaureate degree was to become the minimum preparation in nursing. Although this idea was emphasized by Brown in 1948, steps taken toward a fundamental position by the American Nurses' Association did not occur until 1965. In contrast to the conditions laid down in the Position Paper deeming society as the determining factor in the structures of nursing, studies of hospital role behavior done by Strauss (1966), Byerly (1970), and Taylor (1970), demonstrated that institutional ideologies set the conditions for the structure of nursing.

In Nursing and Anthropology: Two Worlds to Blend, Leininger (1970) described her purpose:

. . . to facilitate the interdigitation between the fields of anthropology and nursing so that nurses will be stimulated to blend together nursing knowledge with relevant anthropological concepts.

Leininger emphasized that cultural integration is a crucial problem for nurses. For example, she stated that the new thrust for community-centered nursing challenges nurses to learn new ideas, to interact with people of different cultures, and to improve nursing care by the recognition of the cultural and social factors which are as integral a part of good nursing care as the physical

and psychological.

Leininger described the transitional states of nursing evolving from pre-scientific to scientific and theoretical. For example, the traditional culture of nursing practice focused on the physical needs of the patient -- keeping the patient fed, clean, protected and warm. The role of the nurse was to assist the physician, to administer medications and treatments and to provide for a patient's physical comfort. Gradually, care was focused on psychological needs. Increasingly, social factors relating to the patient's behavior were considered and, most recently, cultural concepts have begun to make their way into the field and are providing new insights about health problems and needs of people from different communities. According to Leininger, a broad knowledge base to understand cultural differences is the key to successful provisioning of care.

In the historic period from 1973 to 1979, many ideological changes surfaced in nursing. Therefore, selected readings will be analyzed in depth to elucidate many diverse systems of thought.

In 1973, the Lysaught Report -- From Abstract Into Action. The National Commission for the Study of Nursing and Nursing Education was published. The study pointed out that from the beginning of modern nursing in the

United States the practice of the profession has been bound up in the development of the hospital system. The first nurses practiced in hospitals; the first schools of nursing were located in hospitals; the largest single employer of nurses was made up of hospitals; and the image was that of the female dressed in white in a hospital setting. Lysaught defined nursing in a much broader sense which included not only nursing practice as hospital-oriented, but oriented toward health maintenance, disease prevention, and non-acute practice. The National Commission, therefore, recommended that two companion patterns of nursing practice be established.

1. episodic nursing, where the emphasis for practice is essentially curative and restorative, generally acute or chronic in nature, and most frequently provided in the hospital setting.

2. distributive nursing, where the emphasis for practice is designed for health maintenance and disease prevention, generally continuous, seldom acute, and most frequently operative in the community, or newly developing institutional settings.

The Report confronted the distinction between cure and care. Cure and episodic practice related essentially to the treatment and management of illness or injury once incurred. Care was more pervasive since it began with wellness and worked toward sustaining that condition. The Commission believed that much work remains in implementing recommendations for change in nursing roles and

functions, and they anticipated significant changes in the future of nursing practice by basic education changes, continuing education, and a firm commitment to the belief that the final determination of our health system awaits nursing's answer.

Scott (1974) examined the changing health care environment in the United States by a discussion of how citizens are demanding better health care which can be available and accessible within a framework of equitable financing. Scott believed that financial considerations will engender and help health professionals to shape the design for an optimum health care system.

Scott questioned the kinds of nurses which will be needed for practice in a new era. She answered this question by describing the shift from disease orientation to prevention, health maintenance, and promotion. Scott emphasized that the caring processes of prevention (education and detection) need to be developed alongside the promotion of satisfying social functioning for patients and must be implemented in all types of institutional and community settings.

The "expanded role" of the nurse, that is, one who is prepared for highly independent decision making and action in the primary care and the teaching of patients, will be the expected role of the society of tomorrow.



From this knowledge base, a deepening of nursing practice will ensure for people scientific, perceptive, and decisive nursing care to improve the quality of health care. To better utilize nursing competence and to improve health conditions through the best in nursing are the goals.

In education, Scott recommended career ladder opportunities for upward mobility, along with effective continuing education opportunities which will aid nurses toward a focus on the changes in social and health thinking, new resources for care with increasing attention to prevention. Within this scope, Scott stated that a deepened sense of professional accountability will encourage nurses to utilize and maximize their greatest potential toward its fruition.

In Hospitals, Paternalism and the Role of the Nurse, Ashley (1976) explicated the study of nursing development in the United States as to the overwhelming obstacles and lack of progress based upon the discrimination and exploitation of nurses. She presented an historical approach to the study of nursing and medicine in hospitals. By this historical approach, she explored the apprenticeship and paternalistic systems in hospitals. She described the oppressive conditions which hampered the usefulness of the largest group of practitioners in

the health field, and how women [nurses] in the nation's hospitals were used for the economic utility and continued prejudice of the female sex. Ashley reported that mythical notions and social misconceptions about women supported nurses' servitude, keeping them subservient to physicians and preventing the full development of their potential contributions in the health care field.

Ashley believed that the recognition of the origins of paternalistic behavior in hospitals may lead to a more equitable solution -- one related to patient needs and professional nursing's participation in meeting these needs effectively. But, she also believed that nurses must direct public pressure toward formulation of national health policies that will insure the full utilization of nurses' abilities and talents. She stated that the public is misled by the portrayal of nurse's roles by the news media that seldom provide information on new developments in nursing. Nursing is further damaged by the control of organized medicine which does not encourage the public to explore better ways to utilize nursing service.

Ashley concluded her study by recommending that professional nursing must begin to exert open and public leadership in meeting consumer health needs. She

emphasized that nurses' sense of responsibility and accountability must shift from meeting the needs of hospitals and physicians to meeting those of the patient and the public.

Leininger's (1976) document explored the issues related to doctoral education in nursing in terms of the development of disciplined modes of thinking, scientific methods of inquiry, and research approaches to nursing education and practice problems. She stated that societal and professional forces have influenced the development of doctoral education for nurses, and pointed out these influences. They are as follows: the changing role of women in the society; the crisis in health care delivery; the emergence of new types of health care facilities; the need for nursing research; and the need to change nursing to fit societal imperatives. In general, the purpose of doctoral programs in nursing is to prepare researchers, scholars, and top leaders.

Leininger reiterated that caring, as one of the oldest arts of mankind, is one of the least understood phenomena, and it is probably the most critical variable in helping people attain or regain health. Therefore, nursing must move forward to achieve a new kind of health care and different kinds of caring systems (especially for diverse sociocultural groups); and, according to

Leininger, this can be accomplished by the need for and development of doctoral education in nursing.

The components of "The 1985 Proposal" set forth by the statement from the New York State Nurses' Association (1977) called for clarification, elevation, and standardization of the system of nursing education by 1985.

The educational requirement for entry into professional practice would be the baccalaureate degree in nursing; for the supportive nursing career it would be the associate degree in nursing. Titles proposed for these two licensed careers would be: "registered professional nurse" and "registered associate nurse," respectively. Included in the measure were "grandfather" mechanisms to protect the license, titles, and practice privileges of all individuals licensed to practice professional or practical nursing prior to the effective date of legislation.

The rationale for the Proposal was the following: the breadth, depth, and complexity of professional nursing practice required minimal baccalaureate education; and the nature of supportive nursing required a blend of technical-academic preparation. In their analysis, the present system of two, three and four years to achieve registered nurse status was not only confusing but costly; and an orderly system would provide protection for the

public as well as to the licensed professional and practical nurses.

In both intent and content, the 1985 Proposal was consistent with every major recommendation offered since the early 1900's for strengthening nursing education and ensuring quality nursing practice.

Hegyvary (1977) explained a relatively new concept in caring organization -- primary nursing. It is a form of organization that aims to overcome weaknesses in team (care through others), and functional (task-oriented nursing) organizations by establishing nursing responsibility and accountability for specific patients. Hegyvary stated that the central concept in primary nursing is that the nursing care of a specific patient is under the continuous guidance of one nurse from admission to discharge. The primary nurses' role consists of the assessment of the patient's needs for nursing care, planning the care, collaborating with other health care workers in providing day-to-day continuity and coordination of care, playing the vital role of "patient advocate," and evaluating the effectiveness of care. Furthermore, the primary nurse is to be responsible for the total nursing process with a particular patient during the total period of hospitalization. In the hospital, where 24-hour care is needed, Hegyvary stated that although

one person cannot be on duty 24 hours per day, one person can provide the overall direction of a patient's nursing care and work with other members of the staff to see that appropriate care is given. Therefore, a necessary part of the primary nursing arrangement is the organization of the unit staff, shift by shift, to support and complement the primary assignments.

In Transcultural Nursing: Concepts, Theories, and Practices, Leininger (1978) expanded her beliefs about the interdigitation of nursing and anthropology to include definitions, theoretical positions, and research strategies, along with numerous contributions of other authors about transcultural caring behaviors.

Leininger emphasized that caring is the dominant intellectual, theoretical, heuristic, and practice focus of nursing, and no other profession is so totally concerned with caring behaviors, caring processes, and caring relationships than nursing. The term "nursing" is derived from the concept of nurturance which conveys ideas of caring, growth and support. To discover ideas embedded in caring, Leininger proposed the necessity for the development of theory and research. She stated that transcultural nursing is concerned with comparative human nursing behaviors, that is, how people differ from, or are similar to, others in the caring and related

aspects of health behavior. Therefore, she stated that at the core of nursing behaviors are humanistic "caring expressions" and "caring processes" of helping people through a variety of diverse types of personalized relationships based upon cultural values or norms of the client and his group.

A number of other authors contributed to the field of transcultural nursing, such as, Aamodt, and Horn, who elucidated the importance of the caring concept in transcultural studies.

In her book on Curriculum Building in Nursing, Bevins (1978) introduced the process of caring as four stages of development: a) attachment, b) assiduity (intense work between the caring partners), c) intimacy, and d) confirmation. According to Bevis, each stage must be successfully completed since each successive stage includes the behaviors of the previous one. For example, self-revelation, which is the basis for getting to know another person, is a theme that runs throughout the first three stages, but takes on different behaviors at each stage. The sorting of tasks into stages does not imply there is a clear-cut division of caring stages, but the sorting into categories is meant to demonstrate where the major focus and activity of caring usually occur.

Bevis concluded that knowledge about the caring

process, its purpose, organization, and outcome, enables nurses to understand and interact with clients more wisely and with greater caring because they make choices based upon caring knowledge.

Aamodt (1978) inquired into the nature of the care concept and explored variations into the cultural content of caring behavior. Aamodt identified four themes from her ethnographic data in the study of the sociocultural dimensions of care within the world of the Papago Indian child and adolescent. These four themes are: health and healing prescriptions and proscriptions; a multi-person child-caring system; belief and unbelief in powerful objects and events; changes in caring activities within the life cycle. Aamodt explicated each of these areas after giving an account of the importance of the concept of care. She concluded that her major aim was to illustrate ways in which taking-care-of is a culturally relevant domain which organizes human experience.

In the book Nursing, The Philosophy and Science of Caring, Watson (1979) introduced her ideas about nursing in terms of "understanding." She stated that nursing tries to understand people and how they cope with health and illness. In this book Watson pointed out that nursing must achieve a delicate balance between scientific



knowledge and humanistic practice behaviors. She drew distinctions between these two fundamental components of nursing. On the one hand, science is concerned with the ordering of human behavior and is detached from human experiences. On the other hand, the humanities address themselves to the understanding and evaluation of human goals and experiences. Watson stated that in spite of the inherent differences between science and the humanities, there exists the capacity for the science of caring which approaches human problems from both of the directions. The scientific base of caring integrates the biophysical sciences with the behavioral sciences, and so necessitates a recognition and utilization of the humanities. From her analysis of nursing, Watson presented ten primary carative factors that form a structure for studying and understanding caring which include, value systems, interpersonal relationships, scientific problem solving for decision making, a conducive environment and so forth. She developed each one of her primary carative factors utilizing specific resources from the human and biological sciences and humanities to support and complement her ideas. Watson concluded that the goal of such study is the development of a body of philosophical and scientific knowledge that helps a nurse care for another person before, during, and after illness.

Gaut's recent doctoral dissertation of 1979 demonstrated a complete review of the concept of care/caring as a common word, and the concept of caring in nursing education. In her evaluation of caring, Gaut reported that philosophers, behavioral scientists and nurses highlighted three similar points regarding the concept of caring:

1. The importance of the notion of caring as evidenced by the increasing frequency of the use of the concept;
2. The evolution of caring as related to some other concept or concepts;
3. The discussion of activities such as feeding, touching, and talking to, which when grouped together constituted caring.

Gaut's research used a philosophical approach as the basis of an analysis of caring and pointed out that other kinds of questions and problems require attention if nursing is to understand and improve its practice. Gaut concluded that caring is a conceptual problem for nursing, and an adequate theoretical description of caring action is required to deal with the questions about competence arising out of nursing practice. She proposed such a theoretical description for identifying and evaluating caring competency.

From this brief historical account of the concept of care, and the functional role of caring and ideologies in nursing, the final section of this chapter will

involve an examination of select literature relating to hospitals -- first examining the concepts of bureaucracy, and institutional ideologies, and secondly, examining hospitals from a sociocultural nursing perspective.

### The Concept of Bureaucracy

Bureaucracy is important in the analysis of caring within the context of an institution. The study of organizations, and organizational theories is a major topic in itself, thus, for the purposes of this study, only a brief discussion of the concept of bureaucracy will ensue.

Bureaucracy is generally used to refer to a specific set of structural arrangements, and to specific patterns of behavior -- patterns which are not restricted to formal bureaucracies. The structural characteristics of organizations defined as bureaucratic are thought to influence the behavior of individuals -- whether clients or staff -- who interact with them (Shafritz & Whitbeck, 1978).

The notion of bureaucracy has been elucidated by a number of organizational theorists. Their theoretical positions will be reviewed using primarily the writings of March and Simon, Perrow, Bell and Britan and Cohen.

In relation to bureaucracy, March and Simon (1978) have addressed the theories of Weber, Merton, Selznick,

and Gouldner. Weber (one of the first contemporary thinkers of bureaucratic systems) clarified his major interests in the study of organizations with the following:

1. identification of the characteristics of an entity he labelled "bureaucracy";
2. description of its growth and the reasons for its growth;
3. isolation of the concomitant social changes;
4. discovery of the consequences of bureaucratic organization for the achievement of bureaucratic goals (primarily the goals of political authority).

By his system, Weber wished to show to what extent bureaucratic organization is a rational solution to the complexities of modern problems; and perceived bureaucracy as an adaptive device for using specialized skills and as March and Simon asserted -- without exceptional attentiveness to the character of the human organism.

On the other hand, the theorist, Merton, was concerned with human beings, and postulated the position of dysfunctional organizational learning. He claimed that changes in the personality of individual members of the organization stem from factors in organizational structures. Merton emphasized the importance of the consequences of bureaucratic rules for the maintenance of the organization, that is, rules as a response to the demand

for control.

Similarly, Gouldner was concerned with the consequences of bureaucratic rules on organizational stability. He attempted to show in his theory how a control technique designed to maintain equilibrium of a subsystem disturbed the equilibrium of a larger system, with a subsequent feedback on the subsystem. In Gouldner's system, the use of general and impersonal rules regulating work procedures is part of the response to the demand for control from the top hierarchy.

Selznick used the concept of the delegation of authority as a control technique rather than emphasizing rules. He pointed out that delegation of authority could bring about a series of unanticipated consequences in organizational integrity; and he showed how these consequences stem from the problems of maintaining highly interrelated systems of interpersonal relationships.

March and Simon (1978) remarked that many of the control problems for the analysis of human behavior in large-scale organizations stem from the operation of subsystems within the total organizational structure -- the needs of individuals, the primary work group, and the large organization interacting to effect each other.

In his analysis of organizational theory, Perrow (1978) pointed out that a great deal of variance in a

firm's behavior depends on the environment. He declared that goals, history and traditions of firms vary systematically in different types of organizations. One of the critical variants is the type of work done -- the technology. For example, if the work is predictable and routine, the necessary arrangement for accomplishing the goal can be highly structured. If it is not predictable, and non-routine, then theories that emphasize more autonomy, temporary groups, multiple lines of authority, and communications are important. Another crucial factor in organizations outlined by Perrow is the area of leadership. He emphasized that what has rarely been studied is the wisdom, and the technical adequacy of a leader's decisions.

Perrow (1979) supported the concept of bureaucracy and defended it as the dominant principle of organization in large, complex organizations. He remarked that criticisms of bureaucracy as inflexible, inefficient, uncreative, and unresponsive; as well as stifling, are echoes of radical left or right groups. He pointed out that less often seen in organizational literature, are the charges related to its superiority as a social tool over other forms of organization.

In his book on social forecasting, Bell (1973) stated that bureaucratization is a theory of social

development, and in the mid-twentieth century, bureaucracy has become the central problem for all societies, socialist as well as capitalist. Bell also gave an account of Marx's theories. Although Marxist analyses are used extensively in sociological writing, Bell pointed to the fact that Marx confronted bureaucracy in only one essay Critique of Hegel's Philosophy, and other than marginal references, the topic was no longer the center of Marx's concern (1973, p. 80). On the other hand, Bell reported that in Avineri's interpretation of Marx's ideas, bureaucracy was central to understanding of the modern state. As a mediation between these stark differences in view, Bell stated that Marx discussed the role of bureaucracy as a quasi-independent force between the state and civil society, and in his major writings Marx viewed bureaucracy as identical with the state. "The idea, however, that the bureaucracy could be an 'independent' force in modern society disappears from Marx's writings," declared Bell (1973, p. 81).

Anthropologists are concerned about bureaucratization and human social life. Britan and Cohen (1980) discussed the fact that anthropology's early focus on the study of non-Western lifeways is gone, and is searching now for new foci of research and new paradigms. They stated as traditional societies are incorporated into modern

industrial states, the study of complex social systems is becoming important to anthropologists, and pointed out that one of the most central and powerful elements of complex society is bureaucracy. Britan and Cohen see bureaucracies as the crucial link between changing local institutions and the modernizing nations of which they are a part, and believe that the variances of form, function and processes of different social and cultural settings must be studied -- both comparatively, and universally. Thus, for anthropology [and transcultural nursing] bureaucratic research is crucial. The authors concluded that "the study of bureaucracies is, in effect, the study of the most salient and powerful organizations of the contemporary world" (1980, p. 27).

#### A Concept of Institutional Ideology

Bureaucratic ideologies play an important role in the function and maintenance of hospitals. For the purposes of this study ideas from Geertz (1973) and Downs (1967) have been incorporated into the following definition:

Ideology is a system of ideas (mostly verbal) which make empirical claims about the condition and direction of society.

According to Downs (1967), ideologies are developed by top level officials because they are efficient means



to communicating with certain groups both inside and outside their bureau. Each bureau can exist only so long as it can persuade external agents with control over resources that it deserves continued funds by showing them how the bureau's policies and actions benefit them or others they value [in the case of hospitals -- physicians, government, philanthropists, economic resource agents, and research institutions].

Downs (1967) has developed a framework of bureau ideologies by which one can identify the extent to which ideologies play a role in the functioning of complex organizations:

1. Each bureaucracy emphasizes positive benefits, and deemphasizes the cost of achieving them [although changing today].
2. Any changes indicated by a bureau's ideology will almost invariably involve maintaining or expanding its activities rather than contracting them.
3. When other agencies are trying to capture the bureau's functions, its ideology will demarcate the borders of its proper activities. Conversely, when the bureau seeks to invade the territory of other agencies, its ideology will be quite vague.
4. Each bureau's ideology will emphasize the benefits it provides for society.
5. Each bureau's ideology stresses both the desirability and the high present state of its efficiency and centralized coordination.
6. Bureau ideologies must remain specific, rather than general.

7. Every bureau's ideology emphasizes its achievements and future capabilities, and plays down its failures and inabilities. (pp. 242-243)

Downs (1973) emphasized that although ideology is an idealized version of what the top leaders would like to do, the bureau's behavior must demonstrate at least a tendency to move in the directions indicated by its ideology. Furthermore, he stated, since ideology is essentially verbal, it is normally easier to change a bureau's ideology than shift its behavior.

In terms of hospital ideological systems, behavioral scientists have noted that a hospital is a highly authoritarian organization. However, they have been struck by the conflict of ideologies of a "dual" administrative system in which the lay authority system (the board of trustees, the hospital administrator, and administrative staff members) are often in conflict with the professional authority vested in physicians who are "guests" in the hospital in which they practice. In their account of the structure and function of hospitals, Foster and Anderson (1978) expressed the belief that there is no administrative routine which cannot be countermanded by physicians, or anyone acting for the physician.

With this brief background on the nature of ideologies, the remainder of the section will deal with hospitals from a sociocultural perspective.

Hospitals: The Sociocultural  
Nursing Perspective

Throughout most of history, the hospital has been a charitable institution, an almshouse, a last resort for the critically ill poor, and where people have gone to die. More recently, researchers and others note that hospitals have become the primary health centers in the United States.

Foster and Anderson (1978) remarked that the hospital is one of the most complex of all institutions in our society; and it can be viewed as a small society with its own culture, in much the same way as a peasant village or a small tribe is seen as a society with a culture. Furthermore, they claimed that most behavioral science research in hospitals is based upon the small society, appropriately viewed as having "culture," and as the conceptualization for the unit of study.

Foster and Anderson (1978) stated that most studies of hospitals have been conducted in psychiatric institutions, especially by anthropologists because, as most anthropologists believe, cultures take time to develop, and there is likely a greater time span for the development of a viable culture in long-term contacts such as "inmate cultures" of mental hospitals. According to Mauksch (1973) from sociological perspectives, emphases

on a variety of points of view including different types of hospitals, social organization, managerial control, processes, systems, human resources, economic considerations, professionals (nurses and physicians), and patients and patient care have been reported in the literature.

Some studies of hospitals have been examined from the cultural perspective with emphasis on nursing (Byerly, 1970). She stated that the purposes of her anthropological study was to examine how registered nurses in a hospital handled potential and actual descriptions in the work milieu and what effects control behaviors had on the hospital sociocultural system. Byerly identified factors which contributed to increases in tension and a threatened "steady state" equilibrium. She also identified behaviors which appeared to reduce tensions and threats to equilibrium. To maintain this equilibrium in the hospital, she reported that there was an adequate minimum standard for performance maintained at all levels to assure functioning. Byerly also reported that hospitals are institutionalized means for caring for those members of society who cannot care for themselves. In the hospital, many traditional nursing roles to give care were assumed by ancillary personnel which brought into focus more basic questions about the "ideal" and "real"

roles of the registered nurse. Nurses voiced their indecision about their "proper" role. For example, Byerly remarked that nurses competed with doctors for the most worthwhile role in patient care but did willingly collaborate and cooperate with physicians in the common effort to provide care. From her analysis, Byerly implied that there was a need in education for nurses to provide enculturation experiences for the many roles of the nurses; the development of independent practitioners; nursing service and nursing education collaboration to meet societal demands for improved health care services; collaboration for the reconciliation between administrative goals and individual value systems; increased communication; and change in the methods of health care delivery.

Taylor (1970) described hospital activities in terms of organization, management, roles and society. She referred to the patient as preparing for "horizontal orbit" when he/she entered the hospital. In other words, the hospital took custody of the patient's total "being" when the patient experienced the admission procedure and subsequent hospital routines. In describing nursing, Taylor remarked that nurses had three primary responsibilities. They implemented the physician's treatment plan, kept the physicians appraised of changes in the patient's condition, and supplemented and facilitated the

patient's ability to cope. In the discharge of these responsibilities, she reported that problems arose in relation to physicians relating to communication and lack of understanding. Taylor reiterated that when the institution is organized to encourage mutual suspicion, health teams either disintegrate or fail to materialize.

Ray's (1978) applied anthropological study discussed an examination of values and behavior of nurses within the institutional bureaucracy of a hospital which suggested that there is a critical paradox emerging between the behavioral expression of nurses and the professed institutional ideologies. Traditionally, the nursing profession has been oriented toward "otherness," that is, the interests of the patient and the physician stood above those of the nurse. In this study, with institutional goals, and the relative powerlessness of nurses vis-à-vis physicians, prevented the development and implementation of the nurses' own caring model of service. The fact that nursing models of care were thwarted by the organization and physician interests, created stress for the majority of nurses. One major outcome of stress was the fact that nurses began to alter their professional role behavior. The old value system was now being challenged by a younger generation of nurses who saw themselves as professionals seeking personal advancement and gain

within the conditions of the hospital. This study suggested that this new value system has produced a dichotomy between the goal orientation of nursing as "other" oriented care providers, and nurses, who demand self-satisfaction of personal, professional, and social needs. General staff nurses were moving away from their responsibility to others and were becoming more concerned with self interests of a social and economic nature. Most nurses no longer were willing to engage in patterns of self-denial with extended personalized care in relation to the interests of patients, physicians, or the hospital. Thus, Ray stated that nurses' care-orientation, to a large extent, was being undermined by the nurses themselves.

### Summary

The foregoing chapter has provided the background information for the exploration of caring behavior of nurses in a complex institution of the hospital within a midwestern, urban center of the United States. A small number of nurses has become anthropologists, Leininger, Byerly, Taylor, Aamodt, Osborne, Glittenberg and others. They have contributed to the understanding of transcultural health care and health-seeking behaviors of particular culture groups. The subfield of transcultural nursing advanced by Leininger is new within nursing, and

involves the study of cultural similarities and differences of caring components within nursing practice. Social science studies have largely concentrated on the behavior of nurses as it relates to roles, organizational conflict, and management with emphasis on the therapeutic milieu that will facilitate the "cure" functions (that is, support of physician-centered interests). Little has been done regarding the analysis of caring, with the exception of Leininger's (1978) ethnonursing investigations into 17 cultures, Aamodt's (Leininger, 1978; Bauwens, 1978) work with the Papago, and Horn's (Leininger, 1978) description of child-rearing among the Muckleshoot Indians. Byerly (1970) and Ray (1978) investigated nurse role behavior within the sociocultural dimension of the hospital in North American culture. Since there is a paucity of information regarding transcultural institutional caring behaviors of nurses, there is a paucity of empirical information regarding the description of care as practiced by nurses within the sociocultural framework of the hospital. Therefore, the following investigation will involve primarily an inductive research approach aimed at an examination of nurses' caring cultural system within the context of the hospital.

Since this study was primarily inductive, no



specific hypotheses were selected for cause-effect or correlational determination. The goal was to describe caring phenomena for the purposes of drawing clearer distinctions between the cure/care dilemma in institutions; defining caring with an institutional context, classifying care behavior; examining bureaucratic and professional values; and understanding the extent to which the structural characteristics of a hospital impact on the care behavior of nurses. The ultimate goal was the development of descriptive theory/ies of institutional caring.

A methodology for examining those nursing and hospital conditions was comprised of four research questions and four objectives which served as a framework for examining caring values, behavior, processes, and patterns.

To facilitate foundational knowledge of the concept of care and its role within nursing, an historical account of caring, from its identification in pre-history to the more structured occupational notion within nursing, was presented. An historical discussion was helpful in delineating the complex nature of the concept itself and how it is related to human survival, maternal-infant care, compassion, primitive and organized religion, ethnic cultures, and the development of

professional nursing ideologies and practice.

Nursing has been identified as a cultural entity, and hospitals as small societies which have specific cultures, therefore, the study of caring values and behavior of nurses within the institutional framework of the hospital was deemed as critical in laying the foundation of transcultural nursing. Few studies utilized this conceptual tool as a means for discovering transcultural caring theory, thus demonstrating the need to determine the nature of "caring" within the hospital.

The following chapters will describe in detail the methodology, the results, and interpretation of this study. Three chapters will deal with the analysis of caring, and a chapter will include the development and explanatory theory of caring within the sociocultural milieu of the hospital.

## CHAPTER II

### RESEARCH DESIGN AND METHODOLOGY

In the following chapter, the author shall discuss the role of the nurse-researcher as a participant observer and phenomenologist in a study of the caring behaviors of members of her own profession. Included in the discussion are the ethical considerations of qualitative research. Also described are the selection of the setting for the study; the participants involved in the study; the research procedure; the research model, Phases I and II of the research; field notes; other data sources; validity and reliability; theory development; the time frame; and the limitations of the study.

#### Role of the Nurse-Researcher as Participant Observer

Byerly (1976) described participant observation as a role, technique, and a methodology. Brink and Wood (1978) considered observation as a method that we use each day to collect unstructured data around us. What makes it a research method is the degree to which it is

systematically planned and recorded, and both observations and recordings are subjected to checks and controls to insure their validity and reliability.

As a research approach in the study of caring (expressions, and behaviors) within an institutional context, participant observation was a characteristic blend of social interaction which involved direct observation of relevant events, formal and informal interviewing, review and/or collection of documents; and personal attendance at conferences. A distinctive characteristic of participant observation in transcultural nursing (sociology and anthropology) studies is the use of "comparison" in field work analysis. Lewis (1970) remarked that using the semantic term "comparison", rather than the term "comparative method" as a component of anthropological [transcultural nursing] research design broadens one's perspective. "Comparative method" in anthropology is linked largely to cross-cultural comparison in terms of testing hypotheses for the purposes of correlation and covariation. On the other hand, Lewis (1970) stated that the use of the term "comparison" provides for, not only, cross-cultural comparison (correlation), but also, comparisons of human thought, comparisons within a single society (for the author's research, the hospital culture), and for comparisons over space

and time. For the investigator's goals, the use and process of comparison was similar to the ideas and method developed by Glaser and Strauss (1967), that is, posing comparative data of small or large social units within the hospital ranging from persons and/or roles, to hospital clinical units, and to documents. These data allowed for the discovery of conceptual categories of caring; as well as led to the discovery of both a substantive and a formal (grounded) theoretical framework of caring within a bureaucratic system.

Participant observation, therefore, was a method of comparison for collecting cognitive and behavioral data. From basically an inductive approach (although employing four research questions and four objectives as guides), new empirical generalizations of caring were developed.

#### Phenomenology and Participant Observation

During the development of new empirical generalizations about caring, the descriptive and analytic process was phenomenological. Through openness and flexibility to the subject matter, the author was required to eliminate her preconceptions about caring. Bruyn (1970) noted that the roles of participant observer and phenomenologist are similar in that both "tend to let the variables define themselves in the context of the

research. And they examine causal relations between these variables on the basis of the social perception of the subjects themselves" (p. 284). From the use of comparison of caring expressions and behavior, and similar to descriptions of the phenomenological method, the researcher was able to attain an intuitive grasp of the phenomena and describe and analyze caring from three levels (cognitive, institutional, and clinical caring processes). Thus, as Bruyn (1970) pointed out that, although participant observation and phenomenology are not the same in spite of their common differences to traditional empiricism, they both are concerned about how symbols are constituted. For the phenomenologist, it is the study of symbolic meanings as they are constituted in human consciousness; for the participant observer, it is, not only meaning in consciousness, but also, how symbols are constituted in particular cultures.

#### The Ethics of Research

Ethical considerations played an important role in the utilization of participant observation in the study of caring. The nurse as researcher studying her own profession may present problems of bias, however, Byerly (1976) pointed out that the process of participant observation involves the sensitive awareness of behaviors of the persons being observed, and similar insight into

the researcher's own actions and reactions. Stephenson and Greer (1981) claimed that "the ordinariness of observations in a familiar culture increases the danger that these [important observations] may slip away without being recorded" (p. 125). The author found that by employing both participant observation and phenomenological processes, she was more attuned to observations; and that all relevant perceptions and observations should be recorded. Also, the employment of validity and reliability checks during the course of participant observation provided for increased attention to observations, recordings, reflective analysis, and evaluation. The broad data base allowed for the maintenance of objectivity and integrity while at the same time, the researcher noted that attention to the subjective process, also allowed for the unique experiences which were shared during the course of studying members of her own profession.

The ethics of participant observation as related to the interaction phenomena with study participants, however, does bear additional discussion. Research subjects have rights no matter what type of methodology is employed. According to Diener and Crandall (1978) these rights are consent, privacy and honesty. It was imperative that the field observer inform the subjects of the

nature of the study and their right to agree to participate or not. Armiger (1977) identified the generally approved elements of informed consent which are as follows:

1. The subject must clearly understand the precise nature of the study and the potential risk involved.
2. The subject must freely agree to participate without any external pressure.
3. The researcher must explain the potential benefits of the study.
4. Confidentiality and anonymity of the subjects must be assured.
5. The subject may withdraw at any time.

Appendix B of this dissertation is a letter which was designed to acquaint the hospital personnel with the goals of the research. It covered all the vital ethical information necessary to conduct a study of nursing phenomena. Attending physicians were also informed at an executive meeting regarding the research study, and that some of their patients might become subjects of the study. Emphasis was placed on the fact that patients would and were not subjected to any undue stress, and judicious discernment would be and was used by the researcher in selecting participants for the study.

Role names and clinical unit name changes were made in reporting the data to protect the anonymity of participants and the hospital.



## Selection of the Setting for the Study

### The Hospital

This field study was conducted in a hospital setting (St. Jude's Hospital\*) located close to the core of a city with a population of approximately two million people. The community of the core city was represented by a number of ethnic groups besides Anglo-American, particularly, Hispanics and Blacks.

The hospital was an active treatment hospital (in contrast to a chronic or aged care hospital). It had major facilities for approximately 350 beds (including bassinettes). A family practice out-patient center; and a family-centered maternity care program were among the newer approaches to urban care within contemporary culture.

St. Jude's Hospital was operated under the jurisdiction of a religious community of nuns of the Catholic faith, however, 40% of its administration now was from a non-affiliated, organized religious community.

The setting was selected for study primarily because of the support of nurse-educators, and the support and encouragement for nursing research by the administrators

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\* St. Jude's hospital is a pseudonym, and will be used throughout this study.

of nursing care at St. Jude's Hospital. Permission for nursing research was granted at all executive levels of administration of the hospital.

#### Sample Selected for the Study

A number of meetings were held with the executive members of the hospital to determine the sample needed as the sources of caring data. A sample was selected to represent the hospital population in order to achieve the goals of the research.

Purposive and/or convenience samples were selected. For Phase I, a purposive, stratified sample was chosen to allow for different representation from different administrative role groups. In Phase II, convenience samples were chosen because of the availability of nurse, physician, or client groups on each of the clinical units. Samples from the client groups (various cultures including Anglo-Americans) were selected by the researcher in collaboration with registered nurses. In total, 192 participants selected from administrative, nurse, auxillary, support, physician, client, and student groups were represented in the caring study. For the formal interviews (192), audio-taped and recorded semi-structured interviews related to values, attitudes, and behavior about caring in a complex institution were conducted. Informal interviews were also accomplished

and recorded during the course of the research.

Role Names. Although researchers have used many terms, such as, subject, respondent, actor, and informant (see Spradley, 1979, pp. 25-39) to describe persons taking part in research studies, the author chose the terms, respondent and participant, which were used interchangeably throughout this study.

In a study of institutional caring, a variety of occupational roles, such as administrators, nurse-administrators (director, supervisor, head, charge nurses); registered staff nurses, licensed practical nurses, aides, were chosen. (See Appendix A for a working definition of select job descriptions and/or responsibilities of the occupational roles within the hospital.) Appendices D and E are the hospital and nursing organizational charts which served as guidelines to understanding the role stratification system, and the clinical unit organization of the hospital. Bullough (1978) stated that the concept of stratification means the ranking of people according to power, social class, and wealth. Roles in hospitals, generally are ranked according to first, power, and secondly, social class (of hospital occupations). Wealth may or may not enter into the picture, however, wealth in the form of payment or insurance usually determines where a client will be hospitalized;

and the extent of the technology available to staff and clients in the institution.

#### Wards/Units Selected for the Study

The wards/units (see Appendix A) selected for participant observation with head nurses, charge nurses, and general staff nurses were all the units where nursing care took place.

#### The Research Procedure

As outlined in the Introductory Chapter, this study evolved around a purpose and research objectives to investigate caring phenomena of nurses. To summarize, the purpose and objectives are as follows:

1. To compare nurses', nurse-administrators', and non-nurse administrators' values, attitudes, and beliefs about "caring" phenomena.
2. To identify, describe, and define the meaning of caring in the institutional bureaucracy of the hospital.
3. To identify and describe the structural characteristics of a complex organization as they relate to caring values.
4. To determine a classification system of institutional care behaviors.
5. To develop a theoretical framework of institutional caring.

Figure 1 is a research model which illustrates the overall framework of the research.

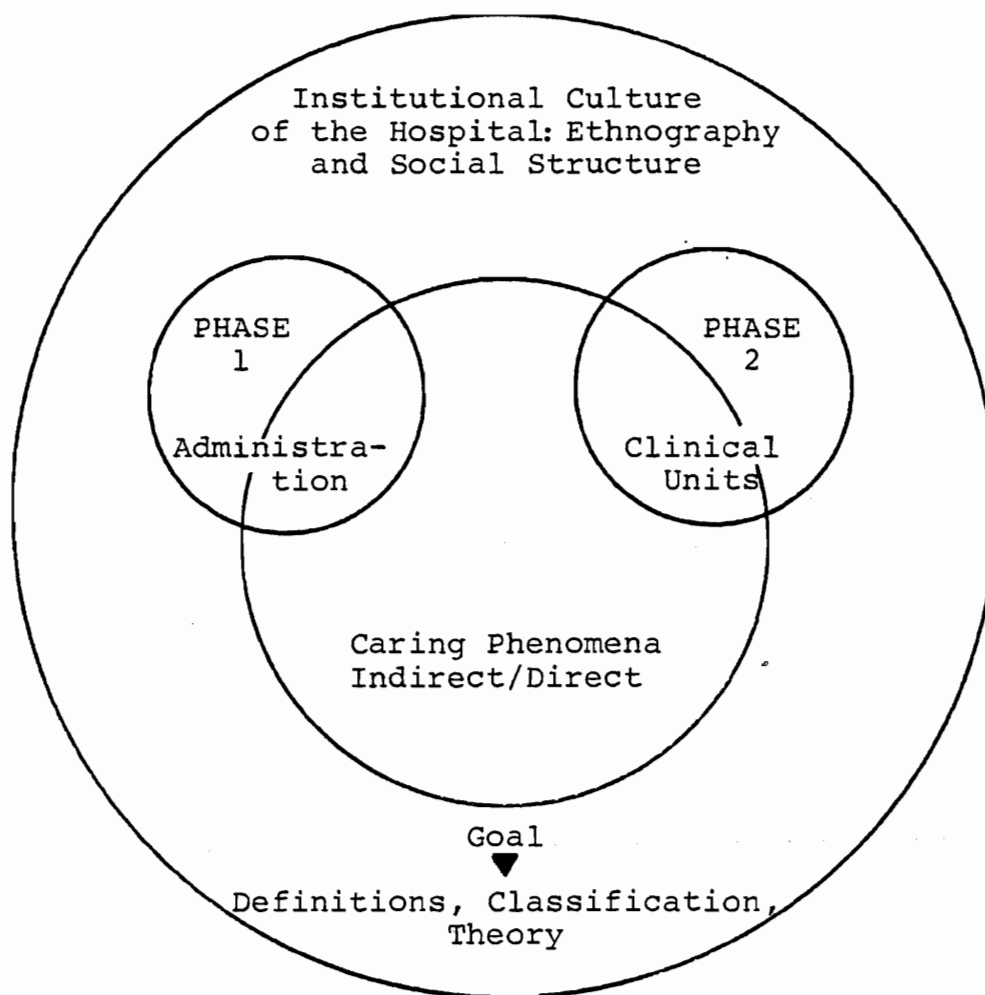


Figure 1

Research Model

### Field Notes

The field notes provided a record of the author's observations during the time of the study. They served as accounts of the stated values of the nurses and administrators; and the author's observations of the social and cultural setting within which the nurses' activities took place.

Some notes were recorded at the time the activity took place; others were recorded shortly after leaving the scene. Discretion was used in terms of when it was appropriate to take notes at the place of activity.

The field notes became the data base from which systematic analysis led to definitions, classification, and theory building of institutional caring. They centered around the comparative factors -- trends, forms, patterns and processes of nurse, client, and administrative values, beliefs, attitudes, and practices within the institutional bureaucracy.

### Other Data Sources

Other sources of data which were transcribed into field notes were the audio-taping of semi-structured interviews and spontaneous discussions in various hospital locations -- corridors, nurses' stations, client rooms, the cafeteria, conference or meeting rooms, or the nursing offices.

Additional sources of unobtrusive research measures were written materials. They included: client charts, client kardexes (nursing care and diagnostic guides), administrative announcements, policy and procedure books, organization charts, the newsletters, union materials, and statements of nursing and hospital philosophies. Job descriptions and personnel policies were among the other data sources used.

### Validity and Reliability

Brink and Wood (1978) presented useful information on the establishment of validity and reliability in nursing descriptive research studies. The authors stated that the difficulty in descriptive studies lies in the fact that the participant-observer is the major research instrument, and the major source of data is the informant, both of whom are human beings -- often unreliable and biased, sometimes unethical. They concluded, however, that an attempt must be made to ascertain reliability and validity. The following were means to accomplish the goal of the caring research of this investigator.

Validity refers to "the degree to which scientific observations actually measure or record what they purport to measure (Pelto, 1970, p. 41). Brink and Wood (1978) stated that Face Validity refers to the fact that

each participant belongs to a group under study, and each member is a carrier of their particular culture. Content Validity refers to the fact that each participant is considered to be an expert on a particular content area, and two or more participants should be used with each content area to establish validity (e.g., participants knowledgeable about caring from the culture of the hospital). Concurrent Validity is achieved by using interviews in conjunction with observations. The researcher compared what participants said with what they actually did in the situation. To validate particular nursing care practices, the investigator utilized the observations of another observer (nurse) to validate impressions.

According to Brink and Wood (1978) establishing validity in descriptive/exploratory studies obviates the need for establishing reliability. Since reliability deals with repeatability, repeated observations of behaviors, events, and situations invariably occurred frequently enough during the course of the study, and this investigator was completely familiar with them. Also reliability can be established by the use of informants as observers. This method provided an estimate of the reliability of the author as an observer.



### Theory Development

The building of theory or theoretical frameworks is central to the development of transcultural nursing knowledge. Leininger's (1978) theory refers primarily to the caring behaviors of specific ethnic culture groups, and is stated in the following way:

Transcultural nursing theory refers to a set of interrelated cross-cultural nursing concepts and hypotheses which take into account individual and group caring behaviors, values, beliefs based upon their cultural needs, in order to provide effective and satisfying nursing care to people; and if such nursing practices fail to recognize culturological aspects of human needs, there will be signs of less efficacious nursing care practices and some unfavorable consequences to those served (p. 33).

Important in Leininger's theory is its relationship to the generation and testing of hypotheses. But, given the paucity of descriptive information about caring, and caring behaviors of nurses in the United States, within their primary employment facility -- the hospital, the researcher proceeded with Level I research and theory generation. Stevens (1979) remarked that explanatory theory is the second step in theory development (second to descriptive theory). Explanatory theory attempts to tell how or why the given constituents of a theory relate with each other -- cause and effect, correlations, or rules that regulate interactions among theory constituents. She differentiated descriptive theory from

explanatory theory by explaining that descriptive theory looks at a phenomenon and identifies its major elements or events (relationship among events), and asserts "what is" rather than "why." Moreover, Stevens purported that descriptive theory was the most important level because it determined what entities will be perceived as the essence of the phenomenon under study. Geertz (1973) an anthropologist, stated to understand what science is, one should look in the first instance not at its theories or its findings but at what the practitioners of it do. In social anthropology [transcultural nursing] the practitioners do ethnography which is not just methods, techniques, and procedures, but what Lyle calls "thick description" -- that is, analysis -- sorting out the multiplicity of complex conceptual structures. In addition, Geertz claimed that there are four characteristics of ethnographic description:

1. it is interpretative,
2. it is interpretative of social discourse,
3. it rescues the discourse in its contexts, and fixes it in perusable terms,
4. it is microscopic (small scale interpretations).

Adopting Leininger's assumption that a systematic investigation of the cultural impact of care behaviors and processes of care are not actually known, and that the concept of care is one of the least understood ideas used by professionals, it was apparent, to this

researcher that Level I -- descriptive theory -- was appropriate subject matter for investigative caring research and the development of scientific caring knowledge about transcultural nursing.

Although the main intent of the research was descriptive, the constant comparative analysis led not only to the development of conceptual caring structures (see Chapter III), but also to the discovery of grounded theoretical frames of reference (substantive and formal). The frames of reference were both descriptive and qualitatively explanatory in that the analysis was accurate and relevant to the area it purported to explain. Thus, the discovery of a formal grounded theoretical frame of reference was an extra benefit to the discovery of descriptive and/or substantive theory.

Glaser and Strauss (1967) stated that although the method of constant comparative analysis can be used to generate static theories, it especially facilitates the generation of theories of process, sequence, and change pertaining to organizations, positions, and social interaction. A study of caring, therefore, produced knowledge of the process of change in relation to caring and how change as a process continually will affect and modify the theoretical frames of reference and positions developed in this research.

### Time Frame for the Study

The total study time took eleven months. The first segment of the research prior to actual caring investigations was spent in preparation. Meetings took place with executive nursing administrators to discuss the research plans, proposal, methods, and the ethical considerations of informed consent. The research proposal was presented to the nursing administrators and the Board of Trustees in September, 1979, whereupon after discussions about the method and ethics, the proposal received overwhelming support. Periodic meetings to discuss the progress of the research were arranged with the administration during the course of time the researcher was in the field.

Phase I investigations (administrative) took place for three months during the hours of 0700 - 1700. Phase II investigations (clinical) were accomplished during a four month span of time, and took place during the twenty-four hour clock.

### Limitations of the Study

A nurse studying the lives of people recognizes both the uniqueness of individuals and the recurring patterns of behavior of those individuals under study. A major limitation of a study of this type was the fact that there was not a multi-disciplinary team of

researchers to describe, analyze, and interpret the caring data from an integrative perspective. Also, regional, national or international cross-cultural comparison of a number of different types of hospitals, and/or other bureaucracies could elicit "caring" data that is much more comparative and more generalizable.

Again, there was the potential for observer bias; however, the use of the mechanisms to establish validity and reliability assisted with this problem.

Caring data were collected from a sample of 33 respondents from culture groups other than whites (or Anglo-Americans). Due to the complexity of the study of caring in relationship to the institution, and constraints of time, a thorough analysis of these data was not done. The investigator will develop fully the portion of the data of caring perceptions and behaviors of different culture groups at a later time. Its importance to the development of transcultural nursing knowledge will be invaluable.

#### Summary

The aforementioned chapter illuminated the various considerations imperative in the development of a transcultural nursing research study of caring within the context of the institution. Participant observation was the technique used to investigate caring phenomena.

Although there was the possibility of observer bias, or important data being overlooked by the researcher in the dual role of nurse and researcher, the incidents did not occur. Both a phenomenological approach which aided the researcher in eliminating preconceived notions of caring, and the use of constant comparative analysis of a variety of social units (roles, patterns, processes) assisted the researcher to achieve the goals of the research. Attention to ethical factors, and the use of qualitative validity and reliability checks too were of the utmost importance in enhancing the dual role toward the accomplishment of goals.

St. Jude's Hospital was selected as the base for the field study because there was a willingness on the part of the administration to support and encourage nursing research. Full cooperation by executives at all levels of decision making was maintained at the time the research was proposed, and throughout the research process. Appendix B is a letter which outlined the objectives, and the ethical rights of persons in relation to their participation in the study. Those rights were made clear to members of the hospital community.

The research procedure that was designed by the investigator (see Figure I, p. 64) included a model for research which demonstrated relevant factors for

comparative analysis within Phases I and II. Comparison served as the method by which a cognitive structure of caring, and grounded substantive and formal theoretical frames of reference were developed.

The sample of participants in the study included nursing and non-nursing administrative staff including physicians and support personnel; and the population was chosen both purposively and conveniently.

Participant observation, semi-structured and non-structured interviews, as well as a host of other modes of resources within the hospital, provided the descriptive information necessary for the sound development of a data base. Validity and reliability measures were used throughout the research to assure its accuracy and relevancy.

The investigative process took a total of seven months so that adequate and complete information was secured to provide a strong foundation from which definitions, meanings, a cognitive structure, and empirical generalizations could be drawn in the study of caring phenomena.

There were limitations to a study conducted with health professionals within the hospital bureaucracy. A multi-disciplinary approach more readily could identify pertinent variables which may in fact differ from

those identified in the process of research of this study. Using other hospitals, or institutions for regional, national, and international comparison could have provided additional supportive data for a comprehensive picture of institutional caring.

And also, because the study was complex, and there were time constraints, caring data from the participants of ethnic cultural groups other than whites represented in the study was not analyzed fully. Therefore, additional analyses will provide more complete knowledge in relation to transcultural nursing.

The following chapter will demonstrate the analysis and development of a cognitive structure (classification system) of caring.



## CHAPTER III

### AN ANALYSIS OF THE COGNITIVE

### STRUCTURE OF INSTITUTIONAL

### CARING

Caring descriptors provided by persons interested and involved in nursing leads to increasing understanding of professional, institutional and general cultural patterns. Vital to building a transcultural nursing knowledge foundation within contemporary culture is the knowledge of caring itself within the most familiar of contemporary cultural settings -- the hospital. The following chapter deals with an analysis of the conceptualization of caring data as perceived by respondents occupying a number of different roles at St. Jude's Hospital. Included are the methods used for analyzing caring data; classification and characteristics of caring; and the multiple meanings expressed through the language of caring.

Three of the five research questions were addressed in an analysis of the cognitive structure of institu-

tional caring. The summarized questions are as follows:

1. What are the expressed cultural caring values, beliefs, and attitudes of different groups within the hospital?
2. Are there different classifications of care/caring within an institution? If so, what are they?
3. Can clear distinctions be drawn between caring and/or curing?

### Methods for Analysis

Ethnonursing methods were used to identify specific cultural caring knowledge, practices, and levels of meaning through semi-structured, and non-structured interviews, participant observation; and documentation of the field data. These methods provided for a direct cognitive analysis of caring.

### Interviews and Participant

#### Observation

Semi-structured interviews with open-ended questions within the process of participant-observation was the principal instrument used for a study of caring knowledge. The investigator interviewed members of her own professional group, other health care professionals, and allied health personnel and found the interviews were a challenge, especially in the hospital setting. The aims of the research were communicated early to all participants, and as clearly as possible either by verbal

statements, and/or by written memoranda. Phase I interviews were with the administrative staff, and Phase II interviews were done in the hospital clinical areas with care providers. Phase I interviews with administrators were scheduled in advance and after consideration of work needs and clinical unit routines, Phase II interviews were scheduled with the clinical employees.

To further identify the role of a nurse-researcher, the investigator wore a nurses' uniform with a name tag in the clinical setting. This approach was accepted by the staff and clients, and its approval was reflected in a client's following comments:

At first, I had a negative reaction to you -- like an invasion. I gave you a time limit,  $\frac{1}{2}$  hour, as I do a salesperson. If things don't turn out positively then I have a convenient way of closing it down. It is important that you look like a nurse. You are not misrepresenting yourself. Also the consent form with the letterhead and the logo let me know you were supported by the hospital.

After the interview, the author asked the client if a questionnaire would have been a more appropriate way to obtain information, but he said that he liked free form and listening; and it netted more because he formed a relationship with the researcher.

This client's responses to the interviewing process are important for the ethics of participant observation research. His statements indicated the importance of

first impressions (relative to how one looks and opens an interview), and the changes which mutually occur in the process of taking an interest and listening to a person and his needs. The investigator observed that the client visably enjoyed the self-awareness and understanding he experienced as he expressed his beliefs and values about caring.

To develop a relationship of trust through sincere motives was an important part of all interviews. Trusting relationships constantly were reinforced. Communication spread throughout the hospital that the researcher was a nurse and genuinely interested in the respondents. Affirmations of trust were revealed by open and frank discussions at the time of the interviews. A number of clients thought that the researcher wanted them to talk about the negative behavior of nurses or lack of "good" care and became apprehensive. Shortly into the interview, however, respondents began to feel at ease, and felt free to express honestly their definitions and beliefs about hospital caring -- how it was, and how it should be. Generally, clients perceived caring differently than care providers. On the one hand, client comments were closely associated to individual needs related to each specific illness or treatment regimen. Nurses, on the other hand, took the opportunity during the

interview not only to identify caring as an ideal but also, their "own" caring needs in relation to the hospital itself. The researcher observed that, on the whole, nurses were in need of a time to vent their feelings. They needed someone to listen. Several participants stated that they felt better after they had an opportunity to discuss caring and their frustrations about the hospital with the investigator. A consequence of the development of trusting relationships was the mutual insights and growth that the investigator and the interviewees experienced.

Only one nurse, an administrator, declined participation in the study. She was approached within the first month of the opening of the research project. However, after several months and toward completion of the data gathering she requested an interview. At that time she made positive comments about the on-going project, thereby acknowledging its value within the hospital.

Positive interactive experiences with the respondents heightened the researcher's motivation and satisfaction which continued throughout the investigative process. In an analysis of client-centered helping relationships, Rogers (1961) summed up this researcher's experience by stating the following:

[The therapists] procedures are less important than his attitudes. . . It is the way in which his attitudes and procedures are perceived which makes a crucial difference to the client [research participant] and it is this perception which is crucial (p. 44).

### Documentation of Field Data

Documentation is a method of analysis, as well as a way in which field notes are recorded. Mishler (1979) characterized the process of documentation as a movement through several levels, which are "not so much steps to be taken one after the other but rather represent a movement toward a fuller understanding of the multiple meanings of the phenomenon [caring], that is, of its coherence, durability, and integrity" (p. 10).

The nature of institutional caring is complex and documentation of the field data helped the researcher to identify a number of factors in the sociology of caring knowledge. The organization of the demographic features of the participants of the study made available the breakdown of the sample population by groups, roles, sex, and culture groups other than whites. Documentation further assisted in the knowledge of nurse-participants' educational preparation; and the development of a systematized classification system of caring to illustrate the multiple meanings of caring expressed within the hospital culture. A systematized classification of

caring permitted a more holistic analysis, and further identified a relationship between the perceptions of the individual and his/her role, and between his/her role and the social structure.

As shown in Table 1, the role representation of the study participants was varied. Administrative and staff nurses are represented the most. Groups of hospital personnel such as orderlies, guards, secretaries and housekeepers are the least represented. University student nurses who were involved in clinical nursing experiences, as well as their instructor, consented to engage in the research activity. Physician respondents were limited to hospital staff physicians and family practice residents with the exception of one "outside" physician because they were difficult to contact and to engage in nursing research.

Also, listed in this table is a sample of different cultural group members, especially Hispanics and Blacks. In transcultural nursing, it is important to identify whether or not caring definitions differ amongst different cultural groups.

Identity of some important elements of cultural caring were established, but since this subject was not the focal point of this dissertation, it was not dealt with fully at this time.

Table 1  
Demographic Features of Role  
Participants

Group	Role	Number			Culture Groups (other than white)				
		Males	Females	Total N	Hispanic	Black	Oriental	Other	Total N
Admini- strator	Non- Nurse	11	17	28		1			1
	Nurse	2	35	37	3	1	1		5
Staff	R.N.	3	47	50	3	1	1	1	6
	L.P.N./								
	Tech- nician	1	15	16		4			4
	Aide		9	9	2	2			4
	Orderly	2		2					
	Guard	1		1					
	House- keeper	1	2	3	1	1			2
	Secre- tary		1	1					



Table 1 Continued

Group	Role	Number			Culture Groups (other than white)				
		Males	Females	Total N	Hispanic	Black	Oriental	Other	Total N
Other	Physician	5	1	6					
	Student	1	11	12					
	Client	15	11	26	4	3	2	5	11
	Educator		1	1					
Total N	14	42	150	192	13	13	2	5	33

Hispanics and Blacks made up more of the non-professional nursing groups, such as licensed practical nurses and aides while Whites constituted the professional administrative and nursing staff. Clients constituted a heavy Hispanic and Black population within the hospital. It represented the response of the hospital to the "health-care" needs of the inner city. (Statistics of the percentage of the different cultural group staff and client population of St. Jude's Hospital were not available.)

Of particular interest in Table 1 is the larger number of female roles than males. This finding reflects a common practice in private hospitals and their social organizational features. Traditionally, a predominance of female care providers has existed in hospitals and especially those which have a religious affiliation and are sponsored by a religious order of nuns (women). Despite the numbers of women in administrative hospital roles, power and authority continue to be exercised by males, especially physicians, who determine the extent to which women, especially nurses, can influence the system. Sexual stratification, therefore, remains as a central problem in the social, political and economic framework of the institution.

Table 2 is a presentation of the respondent's

Table 2  
Cognitive Caring Categories  
of Hospital Participants

Role	No.	Psycho- logical	Practical	Inter- active	Philoso- phical	No. of Caring Responses
Non-nurse Administrators	28	68	78	50	44	240
Nurse-Adm.	37	87	111	63	67	328
R.N.-Staff Nurse	50	145	107	98	84	434
L.P.N./Technician	16	24	25	34	13	96
Aides	9	17	9	14	9	49
Orderly	2	4	3	1	3	11
Guards	1		1	1		2
Housekeepers	3		3	1	1	5
Secretary	1	1	1	2	2	6
Physicians	6	7	14	4	1	26

Table 2 Continued

Role	No.	Psycho- logical	Practical	Inter- active	Philo- sophical	No. of Caring Responses
Students (B.S.)	12	25	5	10	6	46
Clients	26	43	2	37	26	108
Educators	1	1	3	3	1	11
Total N =	192	425	362	318	257	1362

categories of caring systematized by the research in the process of data analysis. Categories are defined by Spradley (1979) as primary types of cultural symbols, verbal, non-verbal, or a symbol object which assist in the decoding of meaning. The four major cognitive categories listed in decreasing order by the number of responses, are kinds of verbal cultural caring symbols which were interpreted and their meaning logically derived from the respondents' definitions and meanings of caring. They are listed as the following:

1. Psychological is defined in relation to two caring components, a) Affective, which is relating to or arising from, or influencing feelings or emotions; expressing emotion, e.g. love; b) Cognitive is the knowledge used to define and interpret actions and events, e.g. decision.
2. Practical, in this study, is defined in relation to two caring components, a) Social Organization which includes the practical consideration and activities relating to the socioculture structural elements of the organization, e.g. political, economic, legal; b) Technical refers to the subject matter organized in relation to techniques, principles, and/or methods; or by way of technology to achieve a therapeutic purpose, e.g. skill.
3. Interactional is defined in relation to two caring components, a) Physical which refers to things relating to the body -- non-verbal communication, for the purpose of providing physical comfort, e.g. touch; b) Social which refers to interpersonal reciprocal action for the purposes of therapeutic outcomes, e.g. communication.
4. Philosophical as defined in relation to three caring components, a) Spiritual refers to a

factor in the social life of the respondents (expressed as caring related to matters of a sacred nature [relation of man/woman with God; prayer; virtuous or ritual acts]), and are seen in functional relationships to other social facts -- ethical, economic, judicial, political or technological; b) Ethical refers to connotations of morality, implications of what is right or wrong, professional and organizational principles, honor, or virtue, e.g. trust; c. Culture refers to perceptions, attitudes and knowledge of the caring needs of persons of different cultural/ethnic groups within the hospital.

These categories are the bridge between the practical definitions of the participants and the abstract thinking of the investigator. The general categories form the basic foundation of the sociology of caring knowledge.

In Table 2, while psychological meanings of caring represented the highest number of caring responses of the four categories the second category, practical, illustrated the current influence of the social structure of the hospital on caring ideas. The philosophical category (especially the spiritual, and ethical dimensions) which in the past was a dominant caring characteristic of Catholic hospitals received the least number of responses.

In Table 3, the differences in the number of caring responses between nurse groups and their educational preparation is presented. The findings revealed that there was little difference in the average number of the total

Table 3  
Nurses' Roles, Educational Preparation,  
Years and Types of Nursing  
Experience

Role	Number		% Average	Diploma	Educational Preparation <sup>a</sup>		Years of Experience				Types of Experience			
	Respon- dents	Caring Respon- ses			B.S.	MA/MS	Less 10	10-20	21-30	31-40	H <sup>b</sup>	PH <sup>c</sup>	NH <sup>d</sup>	ED <sup>e</sup>
R.N. Admini- strator	37	328	10.3	26	13	5	10	18	3	6	37	2		
R.N. Staff	50	434	11.5	40	14	2	28	10	5	7	50	1	1	2
L.P.N./Tech- nician	16	96	16	16			14	2			16		4	
Total N =	103	858		82	27	7	52	30	8	13	103	3	5	2

<sup>a</sup>Some respondents have more than one type of education

<sup>b</sup>Hospital, <sup>c</sup>Public Health, <sup>d</sup>Nursing Home, <sup>e</sup>Education

caring responses between nurse-administrators and registered staff nurses. The licensed practical nurse/technician group had a slightly higher response average than registered nurses. This could be related to the fact that this group is in closer interpersonal client contact than the registered nurse group.

As a matter of interest, in relation to institutional roles, Table 3 shows that although the majority of nurses have diploma educational preparation it shows, too, that 39% of the nurses also have advanced university education (Bachelor of Science, Master of Science, or Master of Arts). This trend is consistent with the changes in nursing educational development in the United States. Table 3 also shows that registered staff nurses with "under ten years" experience continue to have largely diploma educational preparation, and hospital nursing experience is the dominant mode of employment selection in all three role categories. An administrator at St. Jude's Hospital remarked that nurses (including licensed practical nurses/technicians) educated in diploma programs are attracted to the hospital, and the hospital continues to attract nurses who desire to function with less autonomy. Nurses with Bachelor of Science degrees as their initial educational preparation voiced disillusionment with hospital nursing; and many voiced



disillusionment with the profession of nursing in general. Some believed that nursing was a "dead-end" job; while others saw it as having some potential outside the conditions of a hospital. Very few nurses felt they had the power to change or influence the system, thus, hospital nursing became an interim job to more influential employment opportunities.

### Classification and Characteristics of Caring

Table 4 presents a complete classification of institutional caring. Thus, caring can be classified and answers one of the research questions affirmatively.

Durkheim and Mauss (1967) reported (and verified in this research) that in a classification system related ideas are grouped, and can be arranged hierarchically. For the purposes of this study the classification system is also referred to as a taxonomy which has been defined by Spradley (1979) as the internal structure of a unit of cultural knowledge which always approximate the way in which respondents have arranged that knowledge. The researcher abstracted the cognitive categories of caring into Level 1 (psychological, practical, interactional, and philosophical) from the characteristics based upon the caring perceptions and beliefs of respondents. The cognitive categories subsequently were grouped into

levels and arranged according to the approximate ways in which participants responded to the question, "How do you define caring, or what does caring mean?" Thus, this taxonomic classification of caring is a representation of the internal structure of institutional caring.

Levels 2 and 3 represent a further refinement of the internal structure of institutional caring. Level 2 and Level 3 are subcategories wherein Level 2 refers to meaning-types (see definitions in Appendix C); and Level 3 refers to the functions or the functional relationships which are associated with the meanings of each category.

Table 5 shows the characteristics of caring under the psychological category, the first in the hierarchical ordering of caring because of the greatest number of caring responses. Those characteristics concerned with the knowledge level of the psychological category were the highest indicating that professionally, factors related to "knowing" are necessary and important to provide care to clients within the institution. This notion is supported by Mayeroff (1971) who stated the following:

To care for someone, I must know many things. I must know, for example, who the other is, what his power and limitations are, and what is conducive to his growth; I must know how to respond to his needs, and what my own powers and limitations are. Such knowledge is both general and specific.  
(p. 9)

Table 5 also shows the affective or "feeling"

Table 4  
Classification of Cognitive  
Perceptions of Caring

	Cognitive Categories <sup>a</sup>		Caring Characteristics <sup>b</sup>
Level 1 <sup>c</sup>	Level 2	Level 3	Expressions
Psychological	A. Affective	A. Feeling	A. Empathy
	B. Cognitive	B. Knowing	B. Meeting Needs
Practical	A. Social Organization	A. Indirect/Direct	A. Economic/Budget/Money
	B. Technical	B. Indirect/Direct	B. Skill
Inter-actional	A. Physical	A. Doing for	A. Touch
	B. Social	B. Doing with	B. Communication/Talking
Philosophical	A. Spiritual	A. Moral Concern	A. Spiritual Needs
	B. Ethical	B. Moral Concern	B. Attitude
	C. Cultural	C. Concern	C. Equity

<sup>a</sup>See Appendix C, Glossary of Terms

<sup>b</sup>Example only. See Tables 5-8 for complete range of characteristics.

<sup>c</sup>Level 1 ranked highest to lowest in terms of caring responses.

Table 5  
 Characteristics of Caring  
 Psychological Category

Categories			Characteristics	No. of Responses			
Level 1	Level 2	Level 3					
Psycho-logical	A. Affec- tive	A. Feel- ing	Empathy	33			
			Concern	31			
			Feeling	22			
			Loving	18			
			Compassion	14			
			Givingness	12			
			Friendliness (Closeness)	10			
			Enjoyment	9			
			Sympathy (Understanding)	9			
			Patience	8			
			Sensitivity	8			
			Kindness	7			
			Interest	6			
			Motivation	4			
			Cheerfulness	3			
			Intimacy	2			
			Strength	2			
			Tenderness	2			
			Peak Experience	1			
			Vulnerability	1			
						N	= 202
				B. Cogni- tive	B. Know- ing	Teaching	52
Meeting Needs	40						
Knowledge	33						
Observation (Watchover)	28						
Decisions	21						
Assessment	18						
Evaluation	15						
Problem Solving	11						

Table 5 Continued

Categories	Characteristics	No. of Responses
	Integration	4
	Intuition	1
		<hr/>
	N =	223
	TOTAL N =	425

characteristics of psychological caring. Respondents generally presented these ideas at the outset of the interview pointing out the importance of the humanistic and/or "ideal" dimension of caring. The "ideal" dimension of caring in the forms of empathy and concern for clients was desired by most nurses, but they stated that the constraints of time within the hospital counteracted their desires. Their affective definitions, thus, quickly were followed by qualitative statements bound to their role and to the bureaucratic organization.

In Table 6, definitions of caring bound to the organization were borne out, ranking the practical category second within the hierarchical structure of caring. The social organizational level was linked largely to the economy, the coordination of activities and time. Under the technical level, skill (both physical and technological) occupied the top response segment. Practical issues were connected strongly to caring; and represented the changing posture in the determination of caring behavior within the hospital. The shift to practical considerations in modern society is espoused by Bell (1973) with the following comment: "Economic growth entails a general increase in the scarcity of time" (p. 473).

Table 7 represents the interactional category, and is the third of the four categories in the caring

## Characteristics of Caring

## Practical Category

Categories			Characteristics	No. of Responses		
Level 1	Level 2	Level 3				
Practical	A. Social Organization	A. Indirect/Direct	Economic/Money Budget	61		
			Organization/Coordination	41		
			Time	36		
			Legal/Defensive Presence (Being There/Availability)	26		
			Political Competition	21		
			Safety	20		
			Paperwork/Charting	20		
			Woman's Movement	10		
			Control	7		
			Policy Making	5		
			Audit	3		
			Provision of activities	1		
			Managerial Development	1		
						N = 272
			B. Technical	B. Indirect/Direct	Skill	71
					Equipment Maintenance/Design	14
					Technological/Diagnostic Research	3

Table 6 Continued

Categories			Characteristics	No. of Responses
Level 1	Level 2	Level 3		
			Scientific Care	1
			Therapeutic	
			Maintenance	1
				<hr/>
				N = 90
				Total N = 362



Table 7  
 Characteristics of Caring  
 Interactional Category

Categories			Characteristics	No. of Responses
Level 1	Level 2	Level 3		
Inter- actional	A. Phy- sical	A. Doing for	Comfort (Physical) Touch	41 36
				N = 77
	B. So- cial	B. Doing with	Communication (Talking)	80
			Interact (Share)	44
			Listen	32
			Help	27
			Involve	14
			Reassure	13
			Support	11
			Counsel	8
			Rapport	6
			Protect	4
			Nurturance	2
				N = 241
TOTAL N = 318				

structure. The social aspect of interaction outranked physical interaction and the table shows that communication (talking) received the greatest number of caring responses. Bell (1973) predicted that information would be the major criterion in post-industrial society. Thus in the organizational system of the hospital, information in the form of communication-interaction must be one of the crucial areas of bureaucratic concentration and management.

Table 8 represents the final category of the organizational caring structure receiving the least number of responses. The philosophical category consisted of three levels of meaning -- spiritual\*, ethical, and cultural.

Many clients, especially those who were near death emphasized spiritual concerns, and stated how much caring was a part of their response to suffering which they ultimately linked to God, and/or the suffering and death of Christ. Personnel from religious orders and staff, particularly those who were middle age, or who were long-term employees of the hospital referred to spirituality, but emphasized how the Catholic institution had changed.

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\*Spiritual is used here in relation to the definition in Appendix C; and it becomes intelligible when it is viewed not only in relation to empirical activities, but also in relation to the other caring beliefs; and when it is viewed as part of the total system of caring thought.

Table 8  
Characteristics of Caring  
Philosophical Category

Categories			Characteristics	No. of Responses
Level 1	Level 2	Level 3		
Philosophical	A. Spiritual	B. Moral Concern	Spiritual Concern	18
			Faith	8
			Healing	1
			Christian Philosophy (Doing for Others)	1
			Authenticity	1
			Belongingness	1
				N = 30
	A. Ethical	B. Moral Concern	Attitude	27
			Responsibility	24
			Holistic Care	23
			Trust	20
			Individualistic Care	20
			Respect	20
			Self Care	9
			Humanness	7
			Dedication	6
		Ethics/truth	6	
		Commitment	3	
		Patient Advocate	3	
		Honesty	2	
		Sincerity	2	
		Loyalty	1	
			N =173	
C. Cultural	C. Concern	Some understanding of cultural care (interpreters)	30	

Table 8 Continued

Categories			Characteristics	No. of Responses
Level 1	Level 2	Level 3		
			Equity in Cultural Care	14
			No. of under-standing of cultural care	6
			Class care	4
				<hr/>
			N	= 54
			TOTAL N	=257

Some noted that there was less stress upon the spiritual nature of the organization itself (symbolized by the presence of nuns, and caring actions), while others noted that there was more emphasis demonstrated by an active Pastoral Care Department. A nun stated that "spirituality" was now categorized into a department rather than an integral part of the organizational community.

The ethical level had the greatest number of caring responses in the philosophical category. Several respondents stated that attitude was a factor in caring; and several expressed concern about the shift from other-oriented service to more self-centered interests. Attitude, too, was considered a critical component in terms of professional accountability.

A separate category for cultural characteristics of the participants was not developed. Cultural responses were placed in Table 8 under the philosophical category because the term cultural care from a professional standpoint continues to be more philosophical rather than practical. A main characteristic in cultural care, however, was related to the use of interpreters to alleviate the barrier to communication.

Black clients and hospital employees valued equal treatment. Few references to special or different care

based on their cultural group were expressed. Hispanic clients, on the other hand, desired, but not convincingly, special foods of their culture, at times, during their hospital stay.

An important factor in Hispanic culture care was the element of class. An Hispanic client from the middle to upper classes remarked that she did not want to be treated as though she was unable to communicate in English, or understand various hospital procedures. She had these comments:

Don't think that you have to treat me differently, or use slang English because I have a Spanish surname. I can pay my way. My husband and I have our own business, and we live in a nice home and neighborhood. I got mad at the person from the Pastoral Care Department who started to talk to me in low class English; and in Spanish.

This client's comments point out that often cultural care is stereotypical rather than individual. From these data, culture-specific care (specific caring activities directed by the knowledge of individual culture [ethnic groups]) based only on an Hispanic surname produced detrimental results for the client. Thus, culture-specific care requires further identification and investigation within the context of an institution.

### The Meaning of Institutional

#### Caring

Interpreting the meaning of thought and conduct

within a culture has been the central aim of ethnomethodologists, and in this study, the central aim for transcultural nursing. "Meaning, in one form or another, permeates the experience of most human beings in all societies", claimed Spradley (1979, p. 95). Mischler (1974) pointed out the following:

Meaning is always within context and context incorporates meaning. Both are produced by human actors through their actions (p. 14).

And as Polanyi and Prosch (1975) so aptly asserted:

Man [woman] lives in the meaning he is able to discern. . . Men [women] believe in the reality of these meanings whenever they perceive them (p. 66).

Consequently, the role of an analysis of the knowledge of caring was not only to provide a descriptive and explanatory account, but also, to justify the social functions of the language of caring in communicating intent and meaning. The cognitive definitions (although artificially categorized for the purposes of research) were integrally bound together to weave the fabric of the total social/cultural environment. This weaving and interconnection between individuals (behavior patterns and mental functioning) and their environment (social, cultural, economic and political) is what has been labeled as culture and personality research (LeVine, 1973). And as LeVine claims, "nothing is more characteristic of the field of culture and personality than

its concern with transactions between the microsocial domain of individual experience and the macrosocial domain of institutional functioning" (p. 12). In a cognitive analysis of professional caring, the researcher's interest was the relationship of the individual and the institution: the influences of the hospital cultural system on the fundamental caring ideology of hospital employees, especially nurses.

The response rates across the categories showed that the psychological category ranked the highest in terms of caring responses at 425, followed by the practical category with 362 responses. The interactive and philosophical categories are ranked third and fourth with 318 and 257 responses, respectively. Universal definitions or meanings of caring in nursing are referred to generally as "humanistic" (see Gaut, 1979; Leininger, 1977; 1978; 1979; 1980; Bevis, 1978; Watson, 1978), and in philosophy (see Mayeroff, 1971); and client-centered psychology (see Rogers, 1961). Thus, the fact that the psychological category ranks the highest was not surprising. However, the practical category which received so large a number of caring responses was not anticipated by the researcher. In the past, cognitions about caring in hospitals, notably those with a religious affiliation, were related chiefly to spiritual concerns, such as, a



traditional Christian, Catholic philosophy, symbolized by a "Christ-like" commitment to one's fellow man as outlined in the New Testament Scripture reading of Matthew 25:40 (The New American Bible, the New Testament, 1970):

I assure you as often as you did it for one of the least of my brothers, you did it for me. (p. 36)

This value of "Christ-centeredness" was not a prevalent value in this study. Instead, remarks, such as, "All we hear about is the budget"; or "The hospital is big business now". And the following:

The hospital has to meet its expenses -- care will go first. No one wants to admit it.

This statement suggested that there was a change in values identified by the staff which reflects a shift to practical influences with respect to caring activities. Although St. Jude's Hospital professed (see Appendix F), and exemplified a religious\* -caring philosophy by providing a Pastoral Care service (visiting the sick, and opportunities for prayer and communication); and Patient Representative services (opportunities to discuss complaints against the hospital or persons providing

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\*"Religious" refers to man's relation with the holy (sacred; divine essence); subjective religion in veneration and adoration which becomes objective religion when embodied in creed, word, actions (blessings, sacrifice, dance, gestures), and the law (Rahner & Vorgrimler, 1965, pp. 209-399).

service), according to nurse respondents primarily, the practical nature of caring (principally economics, and skill) were given the highest priority.

### Care and Cure Distinctions

One of the chief concerns of transcultural nursing is caring expressions and behaviors, therefore, it is important to determine whether or not there are clear distinctions between what is defined as caring and/or curing. For the purposes of this study, curing is defined as the following:

Using technological or pharmacological and/or surgical interventions to alleviate or abate disease or injury to the body or mind.

Care and cure distinctions were not clear in the staff respondents' statements of caring. Respondents rated skill (listed under the practical category) highly, thereby, supporting technical and procedural activities often associated with the curing routines of physicians. In general, the curing activities in the institutions were as much a part of caring, as were, for example, affective or ethical dimensions.

Clients, however, could distinguish between care and cure. Their interpretations of caring primarily encompassed the ability of the nurse or health provider to treat them individually, and with compassion -- to understand and appreciate their vulnerability to losses of

power and control over their own lives.

The Meaning of Caring and the  
Social Organization

Changes in the structural elements of the hospital social organization are influenced by changes in the dominant culture. Nurses and others are affected by the trends in society -- namely, the increasing interest in economic matters. Despite the all-out efforts to recruit professionals, persons entering and remaining in nursing are decreasing dramatically. Competition has been growing because more nurses are changing occupations to more lucrative jobs with improved benefits, and less responsibility. The value system of nursing now is being challenged. Nurses in this study no longer saw themselves as completely dedicated to the causes of clients, physicians, and the hospital. As one nurse with 36 years experience claimed, "You can't live on dedication!" Another nurse reported that "The important things in nursing right now are woman's liberation, low pay and burn-out." (Jennings [1980] reported that "burn-out is a term describing the state people in the helping professions experience when their job satisfaction is low, and they have exhausted their capacity to give to others in need" [p. 26].)

By attempting to seek more personal reward,

advancement, and economic gain within or outside of conditions in the hospital, conflicts and contradictions are emerging among the caring ideologies of nurses, the institution and the dominant cultural system. What is the meaning behind these conflicts? A simple explanation could be in laying blame on one group or another, or on society, and claim that no one cares anymore. During the course of the researcher's interaction with the respondents and in light of the historical ideas related to caring such an explanation can be negated. People do care. What is different are the types of caring. On the one hand, for the administration, economic and political concerns are interpreted as caring. Considerations of the effective management of money, time, and people are important. On the other hand, a dramatic change for nursing personnel is in the direction of "taking care of the self". The flight from the traditional "otherness" orientation was revealed by nurses and elucidated by various remarks. One experienced nurse commented:

We were taught dedication to the hospital, God, and the patients, but dedication won't buy food or a new car. The hospital still thinks like that though.

A young single parent remarked:

I need money to take care of my family. All this talk about taking care of the hospital is gone by the boards. They don't take care

of us.

Perceiving the management as "non-caring", staff nurses have turned "inward on the self". Unmet needs, that is, lack of personal reward through effective inclusion in an active decision-making role, open communication, and economic gain resulted in overt and covert actions in the form of threats toward union development, and most alarmingly, the burn-out syndrome leading to feelings of alienation, depression, hopelessness, and desertion of their professional commitments, and/or careers.

The psychological, practical, interactive, and philosophical caring categories developed in this study highlighted the notion of interconnectedness between individuals and their environment. When evaluating the numerical responses of participants, the combined psychological and philosophical categories dominated the cognitive structure of institutional caring. In contrast, however, the practical category dominated and strongly influenced social interaction. Consequently, in many ways the political, economic, and legal climate of the bureaucracy, although not negative in themselves, dwarfed the more universal, positive elements of ethico-spiritual-humanistic caring. A new kind of "social linkage" to caring now is necessary, especially for nurses leading from animosities created by altered ideologies,

exploitation in the economic sense, and competition with physicians, technology, and the bureaucracy to a more politically just climate which has the potential to heighten the mutuality of commitment, intent, purpose and action.

### Summary

The development of a classification system and analysis of institutional caring structures represented by Tables 1-8 was the point of discussion in this chapter. Durkheim and Mauss (1967) stated that the object of a classification system was to advance understanding by making intelligible how each category stands in relation to another category, and how together they form the whole. The classification of caring in an institutional setting advanced our understanding of its complex nature, as well as illustrated its logical structure composed of distinct yet interrelated categories: psychological, practical, interactional and philosophical.

Durkheim and Mauss (1967) further pointed to the fact that "a logical hierarchy is only another aspect of the social hierarchy, and the unity of knowledge is nothing else than the very unit of the collectivity, extended to the universe" (pp. 83-84). Similarly, the categories of caring evolving from specific definitions of the concept showed that the relationship among the

society, the social organization and the individual provided a basis for the structural unity of caring knowledge. But, despite, the structural unity of institutional caring knowledge, it remains as yet incomplete in terms of promoting (notably within nursing) employee optimism, hope, and a vehicle for personal growth.

The following chapter will describe and analyze the institutional social and cultural milieu, and more precisely, the profession of nursing, to elucidate the current status of caring ideologies and behavioral expressions within the hospital.

CHAPTER IV

AN ANALYSIS OF THE SOCIAL AND

CULTURAL MILIEU OF THE

HOSPITAL

The following chapter is a description and analysis of the institutional social and cultural milieu of St. Jude's Hospital. The author will describe the institutional social structure concentrating on the character of the hospital -- its history, levels of organization, goals; and physical layout, as well as the social interactions of some of those who compose and articulate that character. Interwoven into the cultural portrait will be the structural elements of the social organization, namely, the health care, ethical-religious-humanistic, political-legal-economic, and the technical-educational systems.

The main research question which was addressed in this chapter was, and is summarized as the following: What are the expressed cultural caring values, beliefs, attitudes, and behaviors of different groups within the



hospital?

A transcultural nursing study of a complex organization has enhanced the researcher's understanding of the cultural and social differences that bureaucratic institutions express. For the purposes of an ethnography of St. Jude's Hospital, cultural and social systems, and the notion of a complex organization require clarification.

First regarding cultural and social systems, Parsons and Shils (Geertz, 1973) posed a useful framework from which to understand the differences. The cultural system is seen as an ordered system of meaning and of symbols, in terms of which social interaction takes place; and the social system is seen as the pattern of social interaction itself. Furthermore, Geertz (1973) added:

On the one level there is the framework of beliefs, expressive symbols, and values in terms of which individuals define their world, express their feelings, and make their judgments; on the other level there is the on-going process of interactive behavior whose persistent form we call social structure. Culture is the fabric of meaning in terms of which human beings interpret their experience and guide their action; social structure is the form that action takes, the actually existing network of social relationships. (pp. 144-145)

Second, regarding complex organizations, the author has applied the notions of bureaucracy in much the same way as Perrow (1979), and Bell (1973) and Britan and Cohen (1980). Perrow (1979) stated that most large organizations are bureaucratic, and he defended bureaucracy

as the dominant factor of organization in large, complex organizations, that is, based upon rational-legal principles. Those principles mainly include: equal treatment for all employees; a reliance upon expertise, skills and experience relative to the position; the introduction of specific standards of work and output; record keeping; rules and regulations binding on employees as well as managers. Bell (1973) discussed bureaucratization as a theory of social development, and like Weber and Perrow, from the imperatives of functional relationality. Bell emphasized, however, that in the next few decades, there will be a desire for greater participation\* in organizational decision making, as well as, increasing requirements of professional and technical knowledge which will form the axes of social conflict. In the anthropological tradition, Britan and Cohen (1980) pointed to the necessity of the involvement of human beings in the study of modern bureaucracies, thus demonstrating the integrity of the discipline in relation to large scale systems, and this contemporary age.

For the purposes of this research, network analysis

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\*Greater participation in organizational decision-making has been called administrative decentralization, a shift from centralized top management decision making. Taylor (1970) referred to this form of administration as "corporate". However, the author chose to use the traditional and more popular term "bureaucratic" to represent both centralized and decentralized administrative views throughout this study.

(views of the environment) was not undertaken, but, the investigator's ethnographic data, with many references to the influences of the dominant social and cultural environment, served as the basis for explanation, and analysis.

### St. Jude's Hospital

#### History

As society has become more complex so has the nature and function of the hospital. St. Jude's Hospital opened its doors as a Sanatorium, owned and operated by a religious order of nuns about the turn of the century. At the time of the first admission, there were 40 beds. In two years the hospital petitioned the city for a name and patient population change from a Sanatorium to that of a general hospital. A school of nursing was initiated within that time, and graduated its first group of nurses in 1905. During the historical period between the first and second world wars, the hospital's clientele included not only persons with general medical, surgical, and obstetrical problems, but also those afflicted with communicable diseases including influenza, and for a period of time, military veterans. Staff physicians recommended expansion of the facilities as the illness needs of members of the community increased, and over time, the

current 350 bed institution was opened in 1964. The hospital grew as the community grew. Technological advances in medical/surgical care necessitated the establishment of coronary and intensive care units by the mid 1960's; and advances in open-heart surgery facilitated the construction of the latest operating and laboratory services to support entry into modern medical care regimens. A new nursing education posture, and a changing economic climate contributed to the closing of the School of Nursing during the 1970's. The "health" shift and different community needs expedited a preventive focus for the hospital leading to out-reach programs in rural areas, a Native-American health program (no longer operational), a family practice residency program, alcoholic, drug and cardiac/stroke rehabilitation programs. including other support service developments, such as, speech therapy, occupational therapy, and social services. An up-to-date life-style management program for employees and the community began in 1980 (Historical Archives 1901-1981, [St. Jude's Hospital], June 1980).

The hospital, once a place to die, and for the poor has become a place of hope, and, as Knowles stated: to which all roads lead in a time of crisis -- be it somatic, psychic, or social in origin (Fuchs, 1974, p. 70). Certainly this phrase is borne out in the historical

pattern of St. Jude's Hospital.

### Levels of Institutional

#### Organization

Wilson (Skipper & Leonard, 1965) claimed that the hospital is probably the last major institutional complex in the modern West to accede to the bureaucratic patterning of work which has long characterized government, big industry, and other large organizations. St. Jude's Hospital was less affected by older and smaller units within the context of its social life, such as, the local religious order of nuns, community religious parishes, individual physicians, and families, and was more and more affected by large systems of formalized well-defined competing structures, such as, the regional religious order of nuns, groups of physicians, the state medical association, state and federal government systems regulating health care, and insurance companies. Although the dynamics of the organization were the outcome of the formal structure, they were also the result of informal organization, such as, social patterns of behavior, cultural integration, and other factors outside its control.

St. Jude's formal organization was hierarchical in nature and functioned on five levels of organization (See Appendices D and E; and Planning Seminar Data, [St.

Jude's Hospital], January 1980).

1. Governing Board is responsible for approving the overall mission and goals of the hospital, planning, and feasibility studies.
2. President and Directors are responsible for policies, objectives to meet goals, long-range plans, strategies; feasibility study preparation; coordination with the regional religious order, and state and federal health planning agencies.
3. Department Heads are responsible for supplementary long-range plans, objectives and strategies; departmental productivity standards, policies and procedures; and input to planning/feasibility studies.
4. Supervisors are responsible for schedules, short-range goals, operational planning, supplementary policies, and some input to feasibility studies.
5. Non-Management Employees are responsible for work routines, minor procedures; some input on long-range plans and feasibility studies.

The hierarchy supported the purposes of the formal organization by identifying the powers of decision making within the scope of specialized performance tasks, and suggested the lines of authority to which each group was responsible. The concept of decentralization in decision making existed to varying degrees within different administrative departments, and to a lesser degree than others within nursing. One administrative nurse stated that decentralization of authority is mostly "lip-service" or "letting people think they are making decisions." She remarked, "The decisions really have already been made before they get to nursing!"

Relating to the hierarchical model of organization was the concern of professionals within the bureaucratic structure. Perrow (1979) emphasized that "professionals" were the hottest single topic in the field of organizational analysis during the early 1960's (p. 52). The roles of physicians and nurses then and now remain as critical variables within the hospital social and cultural milieu. With respect to physicians, they generally are not employees of the hospital but have considerable, if not the primary influence over what happens (Fuchs, 1974), however, subject to authority within their official obligations in the practice of medicine. On the other hand, professional nurses who represented the largest group of hospital employees, were subject not only to themselves, and their profession, but also to the administration and physicians and with little or no control over their own affairs, or those of clients or the institution.

Intra/interhierarchical role positioning existed within this hospital. The anthropologist, Gluckman (1969), provided useful insights into interhierarchical role analysis of district representatives of colonial African tribal peoples. Analogies can be made to nursing. Just as Gluckman's essay underscored the tribal representative's role as the lowest member of the superior

hierarchy (the colonial system), and the highest member of the subordinate hierarchy (the tribesmen), so it is true in nursing. The distinct subhierarchies within the total institutional hierarchy meet in one person, the nurse. Cultural and social perceptions, institutional or otherwise, characterized the nurse as the lowest member of the superior hierarchy (physicians, administrators, and some support service personnel) and the highest member of the subordinate hierarchy (nursing administrators, staff nurses, licensed practical nurses, aides and orderlies). The nature of the hospital subhierarchies were manifested in the following nurses' remarks.

A young administrator lamented:

The knowledgeable nurse acts as a middleman between the hospital and the situation/client. She makes people think -- challenges them. She tries to do what she thinks is right. In traditional hospitals change comes hard even if you prove it. It's difficult to change attitudes. All large institutions -- all hospitals are inherently punitive. You can see the pecking order within units regarding schedules. There are no mechanisms for resolution.

She continued:

Nurses are caught in between. History of caring -- dedication, giving, doing more vs. fee for service -- paying nurses for the service they provide. Nurses are penalized for competency. A "good" nurse floats. She is punished for being good. Caring and dedication to the hospital works against the nurse. Nurses in industry are treated like professionals -- compensated and receive good benefits.



Another nurse remarked:

During W.W. II, we were managers of patient care -- responsible for our actions. There weren't enough doctors around. Today, nurses are partners in patient care -- more professional. Nurses are valuable to the doctor, but doctors let their pride get in between them and the patient.

A supervisor retorted:

The only way nurses can be recognized is to get support -- our first biggest supporters are doctors, and hospital administrators. Hospital administrators are seeing more of what is going on.

An experienced administrator claimed:

I think preventive education post-surgery should be from the doctor. Maybe, it's because I'm an older nurse, and have always looked to the doctor. I see him remiss in his duties not to, at least, have someone educate the patient. I don't know if that should be the nurse's responsibility since the doctor has the overall responsibility.

A young nurse said:

The hospital is trying to listen to nurses and other employees, asking them for opinions, but they don't use it, or follow up. People feel it's a waste of time and energy because they don't explain anything. Nurses have no priority here at all. All departments are the same -- benefits and vacation. I'm not sure that's right. We need participation management to increase job satisfaction. The administration and average nurse are not very good. Right now, we have too many people in the hierarchy. How do we change to become more effective?

She continued:

Occasionally a nurse is treated as a professional. Some doctors treat you professionally, and some treat you like you don't have a brain in your head. They won't let you make

decisions -- have to prove you can do quite a bit.

Bureaucratization and professionalism have been at the forefront of nursing problems since Nightingale. Available literature, and in particular, studies, such as Ashley's (1976) raised the problem of hospitals in relation to the subjugation of nursing values to those of administrators and physicians. Observations of similar incidents and situations were present at all levels of organization in this research. Nursing meetings revolved around complaints: staffing, time-off, full and part-time nursing, budget, physicians, and administrative rules (written and unwritten), regulations and policies. Also for nurses, the most characteristic aspect of bureaucracy, the hierarchy, was judged at its worst. It was, as Perrow (1979) stated, "the negation of individual autonomy, freedom, spontaneity, creativity, dignity and independence" (p. 31).

#### Goals of the Hospital

The goal of St. Jude's Hospital was to provide the highest possible quality care at the lowest cost. Considering the common goal of quality patient care, the sharp gulf between staff nurses and administrators should not exist. However, the additional goal of "lowest cost" has rapidly added to, and created more and more problems

for nurses. "The hospital is big business now." "I haven't got time to care." "We're not allowed to care (not enough staff)." "All we hear about is the budget." "The hospital has really changed in the 15 years I've been here -- for the worst", are statements which reflected the cost-related goals and its effect upon attitudes and perceptions of the employees.

Chief hospital administrators had these ideas. A governing board member claimed:

Care is the second half of the phrase "quality of care". It is adequate or minimal care. In the past the American people demanded the highest quality paramount regardless of cost. Now, we can't afford the highest quality care. Adequate care must be the norm. Care and treatment have been the same regardless of status and social situation. Care is determined economically!

A chief administrator articulated:

The provision of quality care at the least cost is part of our goal. "Best quality" is best medical quality. Quality to us means more than medical quality -- it is social, spiritual and mental. We have a pastoral care center to support that. We need to have a spiritual promotion program that reaches every employee, but the attitudes are different today. A truly caring approach to patient care is to make them comfortable and like the hospital as much as possible. You have to be concerned about all of them.

A system's management director in the hospital reported:

Trying to define high quality care is always puzzling to me. We can measure certain things like a chest x-ray -- as a quality indicator, but someone reassuring you, talking to you, answering questions, being friendly is very important to how someone perceives the kind of

care they get. If they don't perceive the care as good, we hear about it.

A financial affairs representative stated:

To care is to look out for the patient as a person -- he or she comes first. I must be financially attuned to picking up things from patients -- the sick and poor get care along with the others. I have to collect money to keep the hospital going.

While the economic goal was important, the chief sister representing the Religious Order Directorate, and also, nursing, remarked about the importance of the Standards of Care (see Appendix F) -- the general Christian philosophical document as another critical goal of the institution. Her own commitment centered around the humanistic and spiritual needs of her staff and clients. She pronounced:

Care, perhaps, is too simple. It is the whole demeanor of the whole person. The whole approach however doesn't constitute quality. How it is carried out constitutes quality -- with concern and compassion.

Within St. Jude's Hospital administration, there was a desire for both humanistic and spiritual goals, as well as economic goals. But, can they be integrated? Perrow (1979) suggested that organizations must be seen as tools -- for shaping the world as one wishes them to be shaped. Nurses did not visualize the organization in that way, however, given that powerful theme, the hospital as a "tool", must shape its own world. With nurses

at the forefront (the largest single group of health care providers, 1.4 million licensed to practice [NLN Fact Sheet, April 1981]) must be determined to examine and expedite alternatives to the current plight of institutional nursing and caring behavior.

### The Physical Lay-Out of the Hospital

The first floor (basement) of the hospital was the center for supportive and personnel services. These included nursing and employee personnel offices; pharmacy; employee health office; central supply; engineering; purchasing; laundry; housekeeping and the volunteers' office. The attractively decorated main floor housed the administrative, business and admitting areas; the switchboard; a gift shop; the chapel and pastoral care center; as well as laboratories, x-ray, physical and occupational therapy departments. The intensive and coronary care units, operating suite, recovery room, and emergency department were located also on the main floor. The dietary department, cafeteria and conference rooms comprised the third floor.

In-patient areas were located on the fourth to tenth floors. In-patient services consisted of medicine, surgery (including opthamology, orthopedics and gynecology), pediatrics (and nursery), oncology and epidemiology.

Also, adult and adolescent drug and alcohol, and physical medicine rehabilitation, and critical care services were provided. The day-care surgery department admitted clients who required varied surgical procedures and who could receive care for short periods of time, and generally, could be dismissed the day of admission. This new concept in institutional care was designed to reduce costs for both the hospital and the client.

Other services, such as the communication and education departments; nursing midwifery; financial affairs; and physicians' offices were located in adjoining buildings.

#### Parking Facilities

Most employees used the parking garage and lots around the hospital which were provided free of charge, or for a minimal fee. Guards were available and were stationed in convenient locations to escort or protect nurses on entrance or exit from the hospital or parking lots. Nurses on late shifts were encouraged to ask for security guard assistance since the hospital was located in the central city -- high crime district. Guards were proud of their "caring" functions within the hospital. One exclaimed:

I guard people, and the building from others who want to harm.

### Social Interaction

The concepts of social roles and social interaction in the health professions have received wide attention within the behavioral and nursing sciences. Conway (1978) noted that with the growth of scientific knowledge, concomitantly there was a proliferation of roles within health care; and specifically proliferating within the institutional setting. Participants in this study represented many of the varied institutional roles.

Social life in the hospital required that people know what the other means -- how roles are expressed and interpreted. In this transcultural nursing research it attempted to uncover caring expressions and to explicate their meaning and significance.

### Socialization Into Nurse

#### Caring Roles

The process of becoming a nurse is a process of decision, education, and adult and occupational socialization. Professionalism grew from the efforts of Florence Nightingale over 120 years ago, and spread to all parts of the modern world. Lum (1978) stated, "The profession controls the body of knowledge on which its practice rests; it controls the number and kind of persons allowed to practice; it regulates the number and kind of persons entering the profession, and it guides its education of

of these [the] neophytes" (p. 146). During this century, the socialization into the nursing profession has undergone numerous changes, and in recent times, drastic changes. Role redefinition, shaped by societal forces, had led to alterations primarily in educational preparation -- from hospital "diploma" programs to community colleges and universities.

In terms of education, never in the history of nursing has anything caused so much controversy. Differing philosophies of education have resulted in differential emphasis upon the scientific, technological, methodological, and practice domains of nursing. Severe factionalism has been the outcome -- groups against groups; and hospitals generally unable to accept that a new image of nursing has emerged. For example, the following are comments from research participants. A non-nurse administrator remarked:

I heard much talk when I was teaching. I heard people talk of the change in nurses' attitudes over the years as the nursing profession has become populated with more highly educated people. The nurse has moved away from "hands on" care. I seldom hear anyone state that in a favorable way. It always impressed me how widely held the view is that we should return to three year nursing schools because they generated the people who would go into the room, and touch the patient, and show a physical expression of concern. I've heard people holding that view, and these are not only hospital people. The BSN views herself as more of an administrator and less concerned with direct patient care. "I am a nurse; I



am in a uniform; I have a name tag with R.N.". The patient is very surprised when that person seems to be more of an administrator and detached from the patient. They do accept that from a physician specialist. Perhaps, the nurse is more in the mode of the family practice physician where patients expect a warmer relationship.

Another non-nurse administrator commented:

The nursing profession needs to get its act together -- what part they play in the medical care profession, where they see themselves, where they can promote and improve themselves. There are nationwide rifts within the profession -- so many levels of education. I don't know of any other profession that has let itself get into a situation where you can be a R.N., with 2,3,4 years of preparation. Basically, it's all the same. You can have different experience, but when it comes right down to the bottom line, when you present yourself to the labor market -- all three have R.N. after their name.

A nurse-administrator observed:

The BSN can outstrip the diploma nurse in 1 or 2 years. But they come extremely frightened, very little good expertise in a lot of nursing skills. Management, observation and assessment skills are poor because they haven't correlated the book with the patient. Diploma schools led to this problem of expecting expertise on graduation. Those days are gone -- diploma schools are not viable!

A nurse educator related:

Probably a young nurse's concept of caring is different -- is all that knowledge caring? Maybe, they are helping with the patient by having all that. I see decreased caring with increased science.

The criticisms in educational changes ranged from marketing problems, decision-making, knowledge variables to experience, warmth and caring. Leininger (1978)

pointed out that traditionally [hospital educated nurses] were expected to maintain an expressive role -- to be nurturant, tender, loving, protective, sympathetic, compassionate and giving in contrast to what Leininger called the new culture of nursing -- the instrumental role, associated with more managerial, goal directed behavior (pp. 163-164). Does this analysis fit into the remark, "I see decreased caring with increased science?" Does the new culture reflect the value that it is better to be a problem solver than possess the caring characteristics of old? Are they really mutually exclusive? Although not equal in responses, the author's study reflected definitions of caring as both expressive and instrumental. And senior nursing student participants from a university program gave more expressive responses proportionately.

The movement to isolate caring as the central ideology of nursing, and study it "scientifically" has developed only recently. The outcomes of this research as a scientific study of caring demonstrated that caring has multiple meanings within professional and institutional contexts. To determine more specifically the professional caring role of nursing, comparative studies in different settings are necessary.

Societal forces are influencing nursing as never

before, especially the multicomplex changes in the health care system, and the woman's movement. This has created a crisis for American nurses and hospitals. The American Nurses' Association reported that 100,000 vacancies in budgeted full time positions exist. (Heilman, 1981, p. 21; NLN Fact Sheet, March 1981) Numerous articles and advertisements have appeared in the media and expensive recruitment programs have developed to appeal to nurses to "come in" or "come back". What are the causes? Heilman (1981) reported and which is supported by the author's research, that greater need, decrease in nursing schools, woman's liberation, poor working conditions, too little staff, poor wages, little respect, increased paperwork and career "burn-out" are some of the causes.

The woman's movement has been responsible for some changes. The woman's movement, although granting public exposure to nursing, also has had some detrimental effects. Why? Nursing is traditional and not thought to hold any authoritarian or economic power or societal prestige. One young oncology nurse angrily stated the following:

I wonder how many of those women know how important the nursing role is. Some of those "powerhouse" women couldn't do it. The woman's market never mentions a nursing career as a health care role. Women are becoming culturally conditioned. We need to explore our more

intuitive and nurturant behaviors to know the impact on patients.

Nurses concerned about the increasing emphasis on the individual mourned:

A lot of the concentration in school is on the self. You are the important one. But, if you select a service job, you have to put your own ambitions at or below what you are doing in nursing. With the dropping of diploma [hospital] schools, there is less feeling of loyalty to the institution. You are loyal to yourself.

Woman's lib has made the profession good in some ways and hurt us in others. The important things in nursing right now are liberation, low pay, and burn-out.

Caring is really "All American" -- the work-ethic, going that extra mile, loyal, hard working. We don't turn these people out of schools anymore. I don't think anybody wants to be that anymore.

These nurses share their concern with the social scientist Bronfenbrenner (1977). From cross-cultural child research and observations, he believed that caring has been eroded within society; and society has a terribly low opinion of caring, citing the ways in which the two most dependent groups, children and the aged, are cared for. He believed also that children don't learn about caring or how to care. This assumption of the erosion of caring has alarming consequences for nursing. Decreased societal values for caring strain those involved in such practices. Lum (1978) reported that "as in any other role or position social forces and trends move the

individual toward or away from his particular life goals; . . .and people are differentially attracted to occupations by factors such as income, accessibility, and fit of the job to their skills and their personalities" (p. 145). These social forces have taken their toll. Nurses have "burned out", have been damned for their traditional societal role, have been called members of the "pink ghetto"; have caused alarm over their exodus from service, and have been accused in some regions, of drug stealing.

#### Nurse Socialization Process at St. Jude's Hospital

Recruitment and socialization into nursing roles (refer to Appendix A for definitions of the major occupational roles in the nursing hierarchy) at the hospital occurred on several levels: pre-institutional involvement, the hospital, the department of nursing, and the nursing unit. Socialization was both formal and informal; and it was most informal at the nursing unit level.

Pre-institutional Involvement. The shortage of nurses within the past few years has created the need for recruitment policies, and active recruitment. Heilman (1981) wrote that "competition among hospitals in major metropolitan areas is fierce and hospitals in the United States average \$150.00 to \$4,000.00 per nurse;

and the American Hospital Association has launched a huge nurse recruitment and retention program" (p. 21). A new recruiter role at St. Jude's Hospital instituted last year has commanded a comparatively high annual budget for the purposes of travel, advertising, visual arts (brochure designing and packaging), mailing costs and salary. Administratively, new wage and benefit packages (however, low, comparatively) were agreed upon to entice the job-seeking nurse.

Educational preparation in general and marketability of the baccalaureate prepared nurse in particular were the chief concerns of the nurse recruiter. She commented:

There is a philosophical difference in the way the 4 year nurse is educated, and how the hospital is using that nurse. The hospital does not promote an autonomous, independent role -- the doctor is the team! We are pushing "medical science" in acute care, therefore, we are educating "kids" who are unhappy in the real world. The majority of nurses still work in acute care hospitals. If I recruit four year nurses, they move or leave. Statistics tell us that 65% of the active nursing force is married so husbands influence where the nurse moves and what hospital she practices in. The two and three year nurses are the happiest in the hospital. They don't want to hear about autonomy. It turns them off. It's over their heads.

She continued:

The hospital pays the Associate degree, 3 year, and 4 year all the same because they all take the same State Board. Also, the law of supply and demand works now. In the past when we had lots of nurses in the country, the hospital didn't have to pay well. Now, there are hardly enough nurses to recruit so they have to do

something about salaries. Nursing will never have a salary we think is comparable -- no way to pay for the job that's done. "If you save my life, there is no price." Can we ever put a price tag on this? I really do believe in fee for service though. We have to say to the patient, "If you want a nurse with such and such knowledge, you'll have to pay for the nurses", as opposed to all of us paying. All levels of care do not demand the same knowledge, so I think we'll slowly move that way. I don't know if that is good. We won't be able to afford it the way it is.

Economics now is challenging the way the hospital thinks and believes about nursing care. Economics controlled the marketability of nurses generally, and specifically university educated nurses, despite the fact that taking the same State Board examination argument for all levels of educational preparation was always used. The law of supply and demand -- the principle rule in economics which relates quantity to price (Silk, 1978, pp. 67-68) forced the hospital to increase salaries. But increases in salaries are passed on to the consumer in the form of higher costs. Silk (1978) asked the question, whether or not, economics, in its current technical state, was capable of taking on so great a challenge as the exploration of the most profound and important issues affecting human society (p. 27). The crisis in institutional nursing, and the concept of caring in this study, were among the most important in the hospital health care system. If they are not dealt with promptly, they can lead

further to the breakdown of the profession of nursing and, consequently, a loss for society. Nurses and administrators alike must try to deal with the problems rationally, and at the same time cope with the uncertainty of competing political interests -- physicians, government, insurance companies and unions.

Hospital and Department of Nursing. A formal orientation program was designed to acquaint new nursing personnel to the objectives of the hospital and the department of nursing. The introduction to the bureaucratic system of operation -- the organizational chart, job descriptions, staffing patterns, benefits, sick time rules, dress code, safety factors, policies and types of standards of nursing care occurred within the first week of orientation. The hospital did not provide child care facilities but a task force was developed to research the possibility. The Standards of St. Jude's Hospital (see Appendix F) were not distributed to new employees in spite of institutional caring objectives.

Team management and/or primary nursing (direct care) responsibilities began the first week, and continued throughout the second under nursing supervision. A probation system was in effect for 60 days followed by performance level evaluations to determine salary merit increases. Recognition of transitional problems from



student life to work produced a new program granting selected new graduates the opportunity for professional growth under the direction of preceptors.

General staff members were chosen for specific clinical nursing units when skill experience was required, such as, critical care. Skill experience outweighed education in terms of employability of staff nurses in most instances. The distribution of knowledge scarcely was dealt with or contested in the organizational product model of nurses (except in the case of licensed practical nurses and aides). Differing values about nursing education stemmed from different ethical, economic and political interests of the hospital. What is imperative at this time is to allow and facilitate the expression of the varying values relating to caring and the nursing profession to become public.

Clinical Nursing Units. The most significant socialization within the hospital took place on the clinical nursing units. Socialization at this level was a process of learning about the "health" care and organizational systems and involvement with others in "helping" relationships. Hurley (1978) stated that rather than viewing socialization only as unidirectional -- the learner passively absorbing and internalizing cultural norms and content, it should be viewed as more and more

an interactional process in which the socializer and the socializee are mutually influenced. With all learning there is change, and Rogers (1961) remarked that change appears to come through experience in a relationship. Furthermore, Rogers (1961) claimed that the development of a helping relationship is to promote growth, development, maturity, improved functioning, and coping with life. Moreover, he concluded that in facilitating the growth of others in relation to the self, the self must grow.

Within the institutional setting, matters relating to growth and development are one of the critical problems. On the clinical units at St. Jude's Hospital, nurses have been a major part of the organizational growth since its development, but with less than adequate positive personal growth. They have been and continue to be socialized in supporting the goals and functioning and maturation of the hospital by accepting and maintaining the long-standing medical model of service (meeting symptomatic-cure needs within specific time frames). Whenever different supplies, technology, and new facets relating to surgeries or pharmacological needs are introduced, the nurses have patronized them. For example, a head nursing administrator commented that if a new piece of technology is requested by a doctor, he

receives it. However, if another nurse is requested for care (largely to implement the technology), the request often is denied, or delayed. The "helping" relationship then has not been perceived or acted out as a reciprocal process, and this perception of one-sidedness has promoted tensions amongst nurses. In the past nursing education took place in the hospital, and conflicts between organizational, medical and technological goals were slow to arise. But, given the societal changes, education occurring outside the hospital, and educational emphasis upon the nursing content and theories, existing models subsequently are competing and interfering with successful clinical nursing practice.

Other problems have evolved. Names of clinical units generally classified according to medical categories (oncology, pediatrics, obstetrics, and so forth), or floor numbers which have given rise to calling clients by room numbers; also, the names of medical problems reinforced now by the standardization and increasing use of problem-oriented "medical" records have caused difficulty for clients at St. Jude's Hospital. A beginning attempt at Standards of Care have begun to reflect increasing nursing influences. Despite the monumental change in nursing educational systems to more integrated holistic health orientations, St. Jude's Hospital social patterns

almost exclusively have mirrored existing and/or changing medical models with a few rehabilitative units as exceptions. Institutional socialization therefore was effective. Student nurses on the other hand, stated they wanted to maintain their "holistic health" values and have the following reactions:

The team leader is overwhelmed with basic pill-pushing and intravenouses. They don't have time for holistic care.

I barely get my rounds done for a whole day. I barely talk to my aides. It's frustrating and ineffective. It will deter me in any hospital job situation.

I don't want a job with my main objective to get through the day; or get just the meds done.

Our BSN program provides education as a patient care manager. Older nurses were not patient care managers. As handmaidens, nurses were in charge of physician care.

Technological costs are out of hand. We need education for the entire population. Nurses can provide interventions (getting clients in tune with their bodies) at \$10.00 per hour rather than \$300.00 per hour. Nurses should move into their community.

Holistic health care is for the nurse too. Money is not the key point, but if you feel rotten about yourself you want money to feel better. Human dignity and value and reinforcement is what new grads want. They are out there to be effective, not just make the bucks. They want to make a contribution, not do functional nursing. I've internalized holistic care, primary care and the patient manager role. It comes from within. I can't see myself living healthfully if I have to do functional nursing.

Esteem and reward in a human way manifested in

better working conditions and lower patient loads, plus doing the job we are trained, to do, is what I want.

In terms of having a BSN, we are not just caring for meds, or a physical illness. We are back to this holistic thing -- we care for the human being with education and knowledge. We have the background from which to care better. We are taught to care. We can pick up more maladaptations -- know where the person should be in growth and development. Our knowledge is not known -- the public needs to know the difference. I feel ripped off carrying the same tag as others.

Caring is innate, but I spent more time in fostering it in a four year program.

There is a qualitative caring -- the more emotional part, empathy for a patient, and a quantitative caring -- using your knowledge background to improve what is going on with a patient. School has taught me to use it -- to come across to patients as a caring person.

Student nurses felt that, only through public education about nursing, will the urban hospital be changed. Until then, they unanimously stated that they are reluctant to practice in less than the manner in which they were educationally prepared. The exodus from hospital nursing has already begun. The administrative time spent discussing and disregarding these notions must be spent examining their implications for client care and institutional integrity.

To facilitate formal socialization, the design structure of most units was similar. Nursing care was organized by teams (registered nurse, licensed practical nurse and aide) with primary nursing (total care

responsibility of ideally four clients) operating on only one floor.

Each registered nurse team leader was responsible for 14 or more clients, and licensed practical nurses or aides were assigned as team members according to the complexity of care. A chief nursing administrator had the following remarks:

We have different categories of care -- ten all together called the Patient Acuity System [a system designed to evaluate the status of a client in terms of the severity of illness to determine staffing needs, e.g. personal hygiene, elimination, activities, nutrition, behavior, etc]. We are in the process of revising this since our management study was done in 1969, and we all know from experience care has increased in complexity. The Patient Acuity System is only a guide, and we don't have problems with this in justifying our budget.

She continued:

On the 7th floor we had to add another nurse because we have more physician involvement -- where the residents are learning. There are an overwhelming number of orders to be carried out. Because of that learning system, it has added tremendous responsibility to the team leader.

Bitter expressions of discontent about staffing continued throughout the research time. The Acuity System (the "scientific" method) to solve staffing problems was not effected fully. One young nurse in primary nursing stated, "Just as soon as we get a salary increase, they give us more patients to take care of."

Floating has become another way to deal with

shortages. Hostile expressions and abrupt behavioral changes were the result whenever nurses were asked to work on another floor. Nurses feared they would receive the "worst" patients -- people who took a long time (usually the elderly) to care for (usually the people no one wanted to nurse). On a busy ward, for example, one such elderly patient needing attention kept calling out. Ignored by the staff, a physician finally went to his room, and told him to keep quiet because he was bothering everybody. The man kept on yelling out. He later received medication -- the answer to many problems which are time-related.

Another growing trend to ease shortages in the hospital was the use of "pool" personnel from temporary employment agencies, or from the hospital itself. An occupational model such as this offered nurses more freedom of choice, and short term commitments. Although still an insecure system, could this be the future model of institutional service -- a fee for service contract system which could be managed by the professional nurses' association?

The Union. A new wave of informal socialization occurred on the clinical units through sharing knowledge of union activity. Discouraged by the administration and their religious leaders, the rise of union activity

was weakened. A few nurses remarked at how successful the hospital was at bringing in high-powered anti-union people to "union-bust". Although a "subversive" union periodical was published and circulated, an anti-union periodical countervailed. Agreement on the relationship between professionalism and unionism was not reached. Differences of opinion existed, but there was a growing trend toward changes in the "new" professionals. A senior male student had the following remarks:

When you are talking money, unions, communicate to the institution. A 7% raise with a 13% inflation rate and 18% misery rate won't work. Institutions must be aware of the individual. I'm not all that pro-union, but 7% isn't making it. I'm a dedicated human, but I can't eat it. In the breakdown of costs, nurses get so little of the pie. I don't like to see the physical plant taking 25% of the pie when I'm with the patient 90% of the time. I'm like the soldier getting shot at, and everybody back home is getting paid for it. I'm pessimistic about nursing. Good nurses move out of nursing or upgrade themselves and leave the bedside. There are deeply rooted reasons for the upgrade -- you can't get any money as a hospital nurse.

Another nurse responded:

There is a place for unions. Professionals and the union have to come together for more force. Professionalism comes from the global down, and unions from the bottom up. Nurses aren't all professionally oriented -- there is money orientation. I want money. We aren't keeping up with inflation. We're still trying to get what we need for the last 100 years when Nightingale said we would work for nothing.

A uniform way of perceiving a situation develops as people share common goals and experiences. Since many



non-nurse administrators did not share in the common experience of direct, complex client care coupled with low pay and low self-esteem, differences arose leading to organizational disputes. An understanding of perceptual problems relating to the meaning and valuing of contemporary nursing and caring vis-à-vis the hospital organization must be an indispensable process in ending futile and frustrating complaints, and replacing them with constructive and positive negotiations. Levine and Karsh (Stagner & Rosen, 1965) claimed that "the treatment of the white-collar [nurse] by the employer is the decisive factor in white-collar [nurse] attitudes toward unions. When impersonal treatment and regimented working conditions become the rule, the number of white-collar worker [nurse] union members may increase dramatically" (p. 126). These factors have been demonstrated in this hospital; and are developing in many urban "health" care centers across the nation.

#### Structural Elements of the Social Organization

Common to every social structure are a number of categories used to generate and interpret social behavior. The categories of the social structure were defined by Leininger (1978) as "the interrelated and interdependent systems of society which determine how it functions: the

political (including legal), economic, social (including kinship), educational, technical, religious and cultural systems); and health care generally cuts across most of these systems" (p. 61). In the study of a complex organization, the cultural system incorporated all of these social structural elements. Understanding the nature of caring behavior and its relationship to the hospital was essential given the hospital's role and ability to control and create environments it desires. The following is an examination of the social structural characteristics of St. Jude's Hospital which influenced caring behavior, namely, the health care, the ethical-religious-humanistic, the technical-educational, and the political-economic-legal systems.

#### Health Care System

The "health" (medical) care system\* of St. Jude's Hospital functioned within the scope of the symptom-cure medical model. Holistic health care or the integrated health care model (biological, psychological, social,

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\*"Health" (medical) care system refers to the fact that although the phrase health care system (related to educational principles of health prevention, health promotion, and health maintenance) is used within the society, and the institution, the medical care system (curing procedures and activities of physicians or related to the uses of technology, surgery, and/or pharmacology) is the primary model of care in the United States.

cultural and spiritual\*) was discussed to a limited degree, but the total model has not been adopted within the hospital. Isolated care categories were adopted, for example, psychological care dominated within the drug and alcohol clinical units; spiritual and psychological care within the oncology unit; and biological care dominated within the medical-surgical units. Cultural (ethnic group or culture-specific) care was not a dominant value, and related situations or problems usually were referred to the Pastoral Care department. Within St. Jude's Hospital, spiritual care was practiced primarily with the critically ill, pre-operative cardiac clients, and clients with cancer.

A recent trend in institutional care, prompted by intense regional hospital competition, was the health motivation fitness programs (for employees and interested citizens) or "holistic" care as it was often called. Post facto cardiac and alcohol (including some drugs) rehabilitation programs were developed at St. Jude's to meet the newer goals to promote health.

One of the strongest reasons for the lack of an integrated health care system was and continues to be

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\*Spiritual: In a Catholic institution, spiritual care (matters related to Christian, Jewish or other faiths and/or the application of good works in brotherly love) is considered an important part of the general welfare of the hospitalized client.

due to the control physicians (now government and insurance companies) have over hospital policies and decisions. Fuchs (1974) stated that "it is impossible to make significant changes in the medical field without changing physician behavior" (p. 56). And, at St. Jude's as in most "health" care institutions, it is difficult to change physician behavior. Preservation of the sick life of medically dependent people in an unhealthy environment became the principal business of the medical profession, asserted Illich (1973). Furthermore, Illich (1973) pointed out that with the concentration on illness, and increasing surgical intervention, and the rise of pharmacology and technology, the mid-fifties began to witness new kinds of diseases created by medicine [and the author might add, nursing] now known as iatrogenic. With the advent of severe criticism in the last 15 years, some, especially young physicians, are starting to respond with demonstrable concern to the public outcry of the current state of medicine. A physician at St. Jude's Hospital explained:

I believe that the adjective in front of the term, care, is important. Medical care is illness care -- the intervention of the sick and injured. Medical school is illness education. Society needs illness care. People still get sick and die. There is a role for illness care, but there is too much emphasis on it versus wellness care.\*

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\*The form "wellness" care within the hospital usually is considered to be client teaching for health promotion and maintenance.

"Wellness" care was developed (with limited institutional and physician support) by some nurses in critical care, the oncology unit, and with diabetic clients.

A client educator claimed:

The hospital, physicians and nurses must see the value in patient education. In education, you decrease the patient's anxiety, listen, answer questions, and see what they are experiencing with their altered body image. You have to help them work through losses. Education reduces complications and readmissions. There are phases and timing to work out because patients aren't ready to learn all at once. Also, it is more cost-effective to the hospital to have a nurse educator because she is an expert in supply costs and knows how to shop around for the best at the least cost. I feel guilty because other cancer patients other than ostomies and breast cancers don't benefit from what I have to offer.

Clearly, the nurse's comments have reflected that there are positive indications of the relationship between education and improved health status, and also, to the sociocultural environment, especially the economic substrate. Research in nursing, therefore, must be valued and developed.

The Changing Population of the Hospital. An examination of the health care system of the hospital, and the client population demonstrated an increasing aging population. Hess and Markson (1980) stressed that "had not other trends (particularly familial, political and economic) converged to create a particular set of needs among the aged, old age might not have emerged as a

distinctive stage of life in industrial societies" (p. 11), but in fact, old age is distinctive, and becomes increasingly critical when related to the institutional health care system. Hospital statistics reported that close to half (45%) of the hospital population is on Medicare (over the age of 65) (Financial Director; Director of Planning, [St. Jude's Hospital], 1980). The Census Bureau projected that by the year 2030, 17% of Americans would be over 65 compared with 10% currently (1977 Statistics: reported in Hess & Markson, 1980). The number of old people in proportion to the population has become a distinctive element in the hospital social structure. Ideologies and values of care have continued to support the hospital as an acute care center. But, the aging population no longer fits a well delineated "medical" model dedicated primarily to the value of curing. The "acute" care of the "chronically-ill" aged was a personal crisis for most aged, and although unconscious, a collective crisis for the institutional community. Age was a potent factor in influencing the type of care the client received. Many of the very ill aged clients were conspicuously neglected, especially psychologically and socially. Clients engaging in self-care or partial self-care warranted much more attention from nurses. Institutionalization in a modern hospital in many ways has

become a "social" death for the aged in terms of isolation and alienation. An answer to the collective institutional crisis, is the development of learning and new or different kinds of appropriate caring, curing, and organizational ideologies and behaviors. By an enlarged world view of the health care system, meeting the challenges of different cultural-group needs, adapting hospital environments to the changing aging population, and developing different care/cure strategies must be a goal of the hospital community.

#### Ethical-Religious-Humanistic System

The religious tradition of St. Jude's Hospital is Catholic, owned and regionally administered by an order of religious women dedicated to "shield the sick in the service of God." Geertz (1973) stated the following:

Religion is never merely metaphysics. . .The holy bears within it everywhere a sense of intrinsic obligation: it not only encourages devotion, it demands it; it not only induces intellectual assent, it enforces emotional commitment. . .it has far-reaching implications for the direction of human conduct. Religion is never merely ethics either. . .The powerfully coercive "ought" is felt to grow out of the factual "is" and in such a way religion grounds the most specific requirements of human action in the most general contexts of human existence. (p. 126)

Religion, therefore, has been a way of life in most Catholic hospitals. At one time nuns of the particular

order who regionally administrate St. Jude's Hospital occupied the majority of governing positions within the institution. Their presence, and their religious ideology was felt in all strata of the hospital. Now few nuns hold those positions, and some that do are from other religious orders. The exodus from religious orders after the changes in the Roman Catholic Church's Second Vatican Council meetings of the early 1960's and the disenchantment with institutional life, as well as political-administrative roles, caused a decrease in numbers of nuns interested or available for hospital occupations. Also, the transformation of the hospital to a large bureaucratic enterprise has created the need for more business-finance-oriented administrators. Consequently, fewer persons with a total religious commitment influence the system management. Veteran employees recognized, but disliked this change. References to a "big business" atmosphere described their feelings. To many, the "world view" of a religious institution, despite the external symbols, has been distorted. In some veteran employees' eyes, there now exists a disparity between the ideal meaning of a Catholic institution and the present state of reality.

Many symbols representing the meaning of the Catholic religion were present. Some have changed. The



symbolic "cross" of the religious order was visible in each office and client's room. The chapel was also visible from the main floor entrance. Staff and physician representation was sought after and secured for meetings related to Christian philosophy and its institutional effect. A Pastoral Care Department consisting of nuns (one being the Director), Catholic priests, and a Protestant minister represented the hospital's commitment to meeting the spiritual and humanistic\* needs of clients and maintaining the Christian, Catholic ideal of "putting on Christ" (doing good works in the service of God).

These ideas were reflected in a number of clients' comments: "What a great place this is"; "I haven't met an unkind doctor or nurse"; "I've never seen a hospital like this one"; "It's my first experience in the hospital -- it is a wonderful, caring place". The researcher was reminded, however, that unbalanced concern was given to cardiac surgical, and oncological clients, and their families. For example, a religious sister remarked that "we have other patients, and families in crisis who aren't receiving the same type of treatment; we need to

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\*Humanistic is defined as the recognition of the commodity of human values; and the fostering of human growth and development through compassion for and knowledge of one's fellow man/woman.

expand our apostolate".

An important element in relation to the Pastoral Care Apostolate are those differences between humanism and spirituality. Ecumenism among religions has fostered increasing tolerance for new or different ideas and expressions. A nun explained the following:

There is a new concept in religion now. We are all in need, and we need to go out to others. But unless our own needs are being met, we are not going to be able to take care of the patient. Often when I'm in need, I learn from the patients. Three or four older patients have taught me about faith and they had no church affiliation. With patients, we let them set the agenda -- maybe some people aren't interested in religion or spirituality. We then make our visits social -- showing concern, caring, and compassion. I talk to them, reassure them, and hold their hand. I give them freedom to talk -- about death or anything. For Catholics, the Catholic chaplain contacts everyone. We are responsible sacramentally [Catholic religious acts] to Catholics.

From the ethical perspective, Catholic institutional concern for "right-acting" is framed by Judeo-Christian tradition, and bound by the Ethical and Religious Directives for Catholic Health Facilities (1971). A picture of the Code hung at each clinical units' nursing station. Ethical decisions were handled among different groups of administrators, physicians, priests and nuns who dealt with health care values and dilemmas of an ethical nature. In most cases, the Catholic religious ethical point of view superseded humanistic points of

view in the concern for clients' welfare within the framework of a Catholic institution.

Much of the current debate surrounding nursing were the choices between employee rights to unionization; the increasing need for more clinical nurses; the ethical health care dilemma/decisions of care for the aged; the ethics of economic depravity for nurses, and so forth, indicating that uses of religion need to be rediscovered and re-examined in light of the changing sociocultural environment. The nursing staff was of deep concern for, especially, one nun in the Pastoral Care Department. She believed that nurses' needs, both economically and humanistically, were not being met by the administration resulting in frustration for nurses and consequently a lack of sincere attention for many clients. "Caring for the staff should be of prime importance", she contended. This example seems to indicate that, whether or not a hospital has a religious orientation, the nurses' role continues to be conflict-ridden. These data suggest that there must be a recognition of a new ethical politic for nurses within hospitals which could decrease the current defensive control; and also preserve the profession.

#### Technical-Educational System

The technical-educational (including communication) system was one of the most critical elements of the

hospital social structure. Technological changes within the organization were associated with upheavals in hospital management. Improvements in the system can only be communicated by means of education. Woodward (1978) affirmed that "new tools begin to change the task and the new task changes the organization and the qualities required to carry it out successfully"(p.193). An analysis of the cultural and social milieu of the hospital revealed that the competition for technology probably was the most important factor in determining the structural composition and the nature of institutional human relationships.

The Effect of Technology on the Organization. At St. Jude's Hospital, the organization began to change as technology changed -- in structure and in management. To facilitate the growing network of contemporary technologies, the structural design of the hospital was changed and enlarged during the 1960's. The competition for physicians directly related to the competition for technologies which continually has forced service diversification. The cardiac surgical service alone forced reorganization of structural features in the operating room, intensive care unit, laboratory, radiology, and primary nursing unit, not to mention nursing role realignments and changes in authority patterns. To

support more lucrative and prestigious technological changes, the establishment of educational and/or training programs, as well as research and development systems, especially for physicians were necessary creating financial pressures and overall financial increases in the intensity of capital and wage-labor expenditures.

With technical complexity, St. Jude's Hospital has witnessed an increasing number of levels of authority in the management hierarchy, and direct care staff -- adding respiratory therapists, occupational and physiotherapists, pharmacists, nursing and health care educators, specialized laboratory and x-ray personnel, and administrative managers. What was most noticeable was the monumental increases in roles relating to financial affairs -- adding budget officers, data processors, more accountants, and general supervisors. External factors, such as municipal, regional, state and federal government systems, as well as internal factors, have boosted the amount of written material, and audio-visual communication systems, as well as the newer techniques of facility and service short and long range planning, and strategies for change leading to problems of increasing fiscal responsibilities.

To assist in the control of technology, product evaluation and analysis in the form of a Product Review

Committee was designed to keep abreast of the new medical/nursing procedures to decrease hospital, physician and client libability, and to keep within a policy of cost containment. Also, a management specialist stated that because of the intense competition amongst hospitals for physicians and technology, cooperation and/or regionalization of service amongst hospitals would not serve institutional self-interests, therefore, the generation of support continues to be limited. Furthermore, he added:

Nursing is basically powerless in the hospital. The quality of institutional care is a function of its economic health.

The relationship between technology and economics suggested that in order for nursing to deal with change, new economic and political rules are needed to challenge the the conditions confronting it.

The Effect of Technology on Human Relations. Pressures on people at all levels of the hierarchy have built up as technology advanced. Comments from long-term employees demonstrated the changes in the quality of human relations amongst management, staff, physicians, and clients. Community groups have also been affected. To cope with these changing relationships and to try to reintegrate a "technological" hospital culture into a total care hospital culture, educational (both formal

and continuing education) programs were developed primarily, physician programs. A community relations executive stated:

Caring is communication. Everybody has to fully understand what is transpiring to know what goes on in a hospital. More time needs to be spent in medical and nursing schools about communicating to the patient what is going on and what is expected. We are trying to promote holistic health care -- meeting the physical, emotional, and spiritual aspects of the patient.

He added the following:

Our family practice educational program serves the inner-city neighborhood, and it's a family oriented concept -- to promote awareness for prevention and health promotion.

In conclusion, he remarked:

The hospital has been active with community groups: improvement of communication with the community to help the image of the hospital. Also, the most important part of employee relations is that they realize their responsibility in public relations. Every employee of the hospital is part of my staff!

This discussion put forth some of the action required to develop cooperation in the hospital. The efficiency of the organization more than ever will depend upon effective communication systems. However, they will be only as good as they link people together. Given the stated and observed powerlessness of nurses, and the power needed to promote a positive hospital image, the entire concept of education and communication vis-à-vis nursing will have to change.

Changes in communication and client care were happening slowly. Generating from the Department of Education, there was an institutional commitment toward a communication system to educate clients and their families about options and choices available. However, at the clinical level "option care" was provided only by some individual physicians and generally was not a reality. For example, the seriously ill aged usually were subjected to similar technological interventions as the young. Alternative forms of research concentrating on non-surgical or technological interventions were not advanced sufficiently enough. Caring alternatives are in the domain of nursing and research of this nature must be the future goal.

Another important part of the effect of technology on human relations was the area of "quality care". Although an educational expert claimed that the institution manifested behaviors and designated support functions to ensure quality care (by means of audits of medical and nursing care), the director of records stated that the nursing audit was examined in light of adherence to the medical regime (physical cure functions). Communication by nurses, as a function of effective caring was not considered. The management of human nursing resources as a factor in quality care must be rated as a high



priority if the hospital is to function efficiently in the near future. Rogers (1961) asserted "it is not upon the physical sciences that the future will depend. It is upon us who are trying to understand it and deal with the interactions between human beings -- who are trying to create helping relationships" (p. 57).

### Political-Economic-Legal System

The defining characteristic of any organization is the attainment of specific goals. St. Jude's Hospital sought after the highest possible quality care at the least cost. Underlying this goal was the maintenance of the organization through political competition and power; and the identification and allocation of scarce economic resources. Intrinsic to the political and economic hospital organization systems is the legal framework -- dealing specifically with factors related to liability and malpractice. The following is an examination of some of the key elements of the hospital political-economic-legal systems.

Competition and Power. Competing for scarce resources requires power (control over behavior) to secure them. Competition takes on a political theme by developing institutional strategies to deal with the distribution of power (the division of labor), privilege (access

to goods and services), and prestige (recognition, esteem, and honor) (Olsen, 1970).

In strategic competitive operations the external factors of the organization were becoming increasingly more important in the distribution of power. First of all, St. Jude's Hospital was controlled to a large extent by the regional directorate of the religious order of nuns. In conjunction with the rules of the directorate was the power of the state and federal governments, especially, in the areas of federally supported allocations (funds received via the Hill-Burton Act of 1946; with amendments in 1954 and 1964) for construction of additions to the hospital; and numerous other public laws, its most up-to-date, the Health Planning and Resources Development Act with the Amendments of 1979; and the state public necessity directives, principally, certificates of need for institutional materials. The network of local conditions revolved around the total health environment, the product market (what influenced demand for services), and the factor market (land, location, labor, materials, and capital). Internal factors of St. Jude's Hospital revolved around revenue forecasts, capital investments, policies, programs, and internal politics (Planning Seminar. [St. Jude's Hospital] January, 1980).

The local external factors played an important role in terms of competition due to hospital "overbedding" in the urban region of St. Jude's Hospital resulting in duplication of numerous services. An executive claimed that with the dilution of funds to concentrate all services in each hospital there is a dilution of expertise and equipment.

Other components of external strategies were the competition for physicians and technology and most recently, nurses. A chief administrator stated the following:

We have concerns that a sufficient number of physicians use us. We have concern that we have the proper technological equipment, and to provide the physician with the environment that he can work in. Along with that is the care of the patient. If we weren't concerned with physicians and technology, we wouldn't have patients to give caring to. I don't see that we set one above the other.

Despite increasing competition for skilled nurses in the marketplace, nurses believed that priority in the organization was given consistently to physicians and technology. "A powerful doctor can get what he wants", exclaimed an administrator. Moreover, he said the hospital had power centers which he termed as "the politics of the institution".

The politics of the institution were seen most readily in worker behavior through the division of employee labor. Politics created problems in how services were

distributed and the prestige afforded various roles. Generally, competition existed in relation to problems of power and leadership; in policy formation; rivalry among groups (administrators, registered and licensed practical nurses, and aides), "change" decisions; intra-group union activities; and client-staff relationships. In research interviews, nurse respondents in administration and direct-client care believed that their self-esteem had been undermined by the society in terms of the changing role of women, the punitive factors of the institutional administration, the physicians, and now themselves. A number of young nurses believed nursing was a "dead-end" job. One nurse remarked that she never tells anyone she is a nurse because she is ashamed that it doesn't carry power or prestige [she was a head nurse].

In spite of an increased voice in policy decisions and some attempts toward equal treatment, nurses remained dissatisfied. In many ways, nurses resisted change themselves, falling victim to burn-out. Possibly nursing's resistance to change emerged from a lack of perceived political control even though in reality competition for their skills was at an all-time high.

Once a person became an employee, however, competition to develop and motivate nurses to maximize their

skills and strengths was thwarted. Differences in nursing education and ability continued to be mismanaged at St. Jude's Hospital. In fact, the author noted that the only distinction made among levels of nurses in direct care was a legal distinction -- a registered nurse must be in charge legally; and legally she/he (of the nurse group) is the only person allowed to administer intravenous medications. Distinctions according to expertise and education were lacking. Thus, role diffuseness in terms of education and the mismanagement of the division of labor has weakened the political power and competitive ability of St. Jude's Hospital nurses.

Allocation of Scarce Economic Resources. Economics is concerned with the problem of scarcity of public resources. Fuchs (1974) stated that the economic point of view is rooted in three fundamental observations about the world: resources are scarce in relation to human wants, resources have alternative uses, and economists note that people have different wants, and there is significant variation in the relative importance attached to them. Lately, the economic point of view has infiltrated the hospital system to such a level that in this research "caring" definitions revolved around economic terms. General inflation was responsible for the rising hospital costs, but so were the allocation of health care

resources, in particular, increased technological resources; increased supply and labor costs; lack of cooperation amongst health-related facilities; government regulation; and federal insurances (Medicare, Medicaid) and private insurance companies. This topic is much too large to discuss fully, but suffice it to say that the health care share of the gross national product has expanded from 6.1% in 1965 to better than 9% in 1980 -- double what is spent on current national defense.

(Changing Times, February, 1981).

Caught in the middle of these rising costs are nurses whose salaries have not kept pace with inflation, nor are they equitable in terms of required education, experience, and overall clinical and administrative responsibility. Nurses continually reported how they could increase their salary with little or no education by working as a check-out clerk at a supermarket. Nurses, however, often were blamed for increased salaries in hospitals because they are labor-intensive. A nurse stated that when they received their last monetary increase, they received another patient to care for. A major problem was the lack of economic nursing value in its own right. To exemplify these points Ward (1975), a health economist, explained the heart of the problem with the following comments:

. . .For each day, the patient pays first a basic charge for room, board, and routine care, and that charge depends upon the type of accommodation (private or semi-private). The hospital then itemizes separately other services: medications, x-rays, laboratory work, use of the operating room, or special equipment (such as a heart monitoring device). This breakdown is by no means complete in establishing different service utilization by different patients. The principal variation in utilization not accounted for is nursing services. Some patients may require nursing services two or three times hourly, while others are ambulatory and rarely see a nurse. About the only nursing variation accounted for is round-the-clock monitoring of patients in the critical care or intensive care unit (p. 66).

While economists make these statements, they continue to concentrate their interests on technology, physician problems, the bed occupancy rate, and some labor factors. Nurses continue to be economically valued in terms of their relationship to physicians and hospitals, not in terms of their relationship with clients. Nurses at St. Jude's Hospital were beginning to pull out of the inefficient bureaucratic trappings by an "acuity system", but at the time of this research it had not been implemented. Nursing care must consequently be evaluated as an economic commodity to demonstrate its effect on the health and welfare of clients, and its economic impact on bureaucracies.

Liability and Malpractice. Fenner (1980) wrote that "laws are the rules of conduct that protect the social fabric" (p. 77). Furthermore, she stated that justice,

grievance discussion. In the last few years, the hospital has not been sued. St Jude's Hospital patient representative also claimed that she is the liaison between the "patient" and the hospital. After she received a complaint, her challenge was to get to the patient in a timely fashion, address the situation appropriately, keep the problem contained, cut across any channel in the organization to solve the problem, and make follow-up visits. According to hospital statistics, the referral pattern showed that clients contacted the patient representative 23% of the time, with family members calling 11%. Nursing service called the most frequently, 35% of the time, with other employees 19%, and physicians almost 10%. (Patient Representative Statistics. [St. Jude's Hospital Annual Report] 1978). Viewed as the "patient's best friend" by public declaration, the patient representative follows a legal prescription for preventing malpractice problems by establishing rapport and communicating effectively. Fenner (1980) pointed out that "many of the classic court cases that have produced medical malpractice law appear to have been founded upon, or to have involved, substantial miscommunication" (p. 105). It is interesting to note that nurses who have always thought of themselves as the client's "best friend" have displaced themselves, or have been



change, reasonable and prudent conduct, and responsibilities attendant to rights were the four distinct and intertwining principles of law (p. 86). In recent times within hospitals, increasing legal factors on the part of care providers were coming into play challenging care providers to be more responsible and accountable for behaviors under their areas of commitment. The general public has been influenced by formal legal proceedings to solve problems, and this influence can be felt within the hospital. The number of malpractice suits filed against hospitals, their employees, and physicians, has risen in the United States. Reactions to the suits, and the enactment of the consumer Bill of Rights legislation (1976) produced change, and the most significant change in many states was in the development of a new "patient representative" role initiated in hospitals with over 50 beds. (Director of Planning [St. Jude's Hospital] January, 1980). An administrator remarked that consumers needed some kind of legal backing, and in the many eastern U.S. urban hospitals, the role has proved to reduce malpractice suits by one-half. St. Jude's Hospital initiated their "patient representative" role over five years ago and statistics indicated that fewer and fewer complaints were registered. The patient representative was to reduce malpractice by encouraging communication and

displaced, and are now replaced by a new legal role designed to adjudicate complaints primarily generated by nurses themselves. Where once communicating and developing rapport was a normal function of nurse caring behavior, it now has been turned over to people presumed to, and in many cases, who actually can communicate better. The role, although effective, is a sad commentary on health care professionals, especially nurses.

### Summary

The foregoing has been an analysis of the institutional impact on caring at St. Jude's Hospital. The researcher undertook a number of tasks: to describe and analyze the social and cultural milieu of the hospital in relation to its history and the rise of the hospital as a complex organization on a large bureaucratic scale; an account of particular aspects of increasing bureaucratization ranging from the levels of organization, the goals of the institution, to the changing physical structure which accommodate the needs of its complex "medical" care system. Also, in the organization, human beings were at the helm. Therefore, in this chapter, socialization into caring roles, especially, roles related to nursing were analyzed.

The final task delineated the fundamental structural elements of the social organization as they affected

caring behavior and the hospital itself, namely, the "health" (medical) care system, the religious-ethical-humanistic system, the technical-educational system, and the political-economic-legal system. Each system was distinct, but yet was an integrated cultural whole demonstrating the coherency of the hospital bureaucracy.

These tasks have been large ones and a number of major components of the system may have been ignored, however, the major issues of the institution that were important to nursing were addressed. It appeared that increasing bureaucratization of the hospital has advanced the political and economic components more than the other structural elements within the hospital culture. Since political and economic factors dealt with diverse interests and values, the increased tension and conflict may be unavoidable. The institutional community was at a turning point; its members were faced with critical decisions about the future of a "caring" institution recognizing how the meaning and structure of caring is interwoven into the total fabric of the bureaucracy itself. Caring was and is not an isolated entity, but a part of an institutional framework. Thus, the social context of caring now calls for social cooperation. It will be in social cooperation where a new unity of caring knowledge will facilitate new mechanisms for anticipating

the needs of the "bureaucratized" future.

The following chapter will be an analysis of the networks of caring within each clinical nursing unit within the hospital.

## CHAPTER V

### AN ANALYSIS OF CARING WITHIN

#### CLINICAL NURSING UNITS

Social life in the hospital organization is generated, maintained or changed through a network of social relationships. Fenner (1980) reported that there are some two hundred and fifty allied health professions currently functioning within the health care system. This figure demonstrates the extent to which the contemporary health care system has grown in size and complexity. Hospitals have been a major part of the growth.

This chapter will deal with an examination of the social relationships of care providers (mainly nurses), and clients within clinical nursing units at St. Jude's Hospital. The data were gathered by participant observation on all clinical units, during all three shifts of the twenty four hour clock throughout the hospital for a four month period. The data were examined and compared. During this process of analysis, differential patterns and trends from clinical caring perceptions and behaviors

were discovered. These patterns were abstracted by the researcher into concepts which explained the pattern differences. A structure of caring, or an institutional pattern of caring emerged forming the basis for the development of a substantive theoretical frame of reference called differential caring.

The research questions addressed in this chapter are primarily three of the five questions. They are summarized as the following:

1. How are caring behaviors manifested within various clinical nursing units within the hospital?
2. Are there different classifications of care/caring within an institution? If so, what are they?
3. Can a theory of institutional caring be formulated?

### Clinical Caring Relationships

In this transcultural nursing study the phenomenon of caring was explored. Caring perceptions and behaviors have unfolded through many events -- education, beliefs, and the psychosocial forces of family, organizations and society. Thus, people engaged in institutional social life view and relate to one another and things from a life-style steeped in the influences of their own cultural milieu.

For nurses in this study, interactive networks with-

in the hospital were their sources of both motivation and grief. For clients, the interactive networks often determined their physical and psychosocial survival. Hospitals, thus are critical to the growth and development of human beings who become a part of them.

A young administrator spoke these words:

Caring is a special something. I'm not sure we have the right to sell caring. To have someone care about you, rather than just for you means they have feeling for you. Right now, we pay only for superb nursing care. We luck out if we get someone who cares about us, and is concerned. We have to ask the question, "Is caring something meaningful, or is it just to maintain something (like a profession)?"

The following is a description and analysis of caring expressions and behaviors in relation to nurses, and other care providers, and clients, in an attempt to answer the above question.

#### The Emergency Department

The Emergency Department was a place of fear and of hope. People came through the doors in states of crises in one of two ways, either as "true" emergencies -- trauma or serious illness; or out of fear and loneliness, "learning" that care can be sought and provided at a hospital. The care of strangers became the hallmark of the Emergency Department. One group of strangers was accepted and welcomed. The other group was scorned and rejected. Closely linked to all emergency care was the

relationship of human cultural groups to a technical, political, legal framework. A physician maintained:

In the emergency room, there is a need for technically competent care. The humanism of care is not as important. It doesn't matter how nice you are if the heart stops. You need technical competency. The E.R. nurses and doctors do interact -- not all trauma is life-threatening. Humanistic care and technically competent care are not mutually exclusive, however. In the E.R. you need communication. The patient needs to leave the department feeling good. You need to get to know a stranger -- you have one chance. Usually you'll never see this person again. With strangers you need to order tests -- increased x-rays because of malpractice. We need to decrease the 10% collectible malpractice in emergency departments. To do that here, we have After-Care Instructions which are also in Spanish which have to be signed by the patient after they are explained. They become a part of the permanent record.

Protection from malpractice suits was taking up more and more time for emergency room personnel. One of the staff nurses said they were so self-conscious about being sued, and as a consequence doctors run up large bills. He exclaimed:

A patient may come in two to three times a month. Even though there may be nothing wrong, they will do all the lab work and x-rays to cover themselves legally.

Legal concerns were growing even in one of the most fundamental components of human interaction -- "touch". A nurse stated that now one could be liable for suits if they touched a client without his/her permission. In observations, however, nurses working in St. Jude's



Emergency Room did touch clients for procedures, for the provision of assistance, and reassurance. A nurse with thirty years experience was concerned about maintaining a close relationship with clients and had the following comments:

I try to care for the patient as a whole person, enveloping the family. I try to get through to them even when they tune me out. I believe strongly in patient-contact. Even if someone is comatose, I touch them and talk to them. The technical procedures also involve touching. The ability to care is from within -- it's individual. The younger nurse is more business-like. I try to share with them. I think nursing was shallow for a period -- now we are going back to a more intense, caring process. The frustrations come with short-staffing. In the E.R., nurses are very good. They decrease anxiety -- reassure the patient -- give them a call light.

"Touch", long considered an essential component of human caring (see Leininger, 1978) was creating a challenge for nurses. With increasing literature on litigation and rising legal fears, "touch" in emergency departments could be either a thing of the past, or by asking permission, it could improve levels of nurse-client communication.

Given the strong tendencies toward the practices of defensive medicine and nursing, decisions were in the hands of health professionals as to whether or not "legal caring" would be detrimental or facilitative. It was certain that legal care was detrimental in the wake of

malpractice suits. It was not certain, though, how other legal situations actually could improve the effects of health, such as, teaching through "After-Care" Instructions (currently, return visits were high indicating little success). Research into legal factors, however, could net information to determine how legal concepts could be successfully integrated into caring.

External political factors also have appeared within the context of the Emergency Department. People who were dependent upon government insurance systems frequented the department. Close to 45% of the hospital population was under Medicare, and 10%-15% was under Medicaid insurance systems (Director of Planning. [St. Jude's Hospital] January, 1980). The Medicaid system, primarily affecting minority groups, was a source of constant irritation to emergency staff. A registered nurse commented:

I believe in caring totally for the patient. As a R.N. I am concerned in their present state or in two weeks. Does a patient understand how to care for himself? If the patient can't care for himself he'll be back to the E.R. in a few days. Many Medicaid/Medicare people come in for colds and sore throats. The minimum fee is \$50.00. Sometimes when you try to explain to Medicaid people -- they say the government is paying, so it's okay. We try to channel them to Family Care. The doctors get angry. We need patient education. Doctor's offices are nil for education -- they see the patients, give them a med, and send them home. Here we usually are too busy to spend time talking with the patient. We give them After-Care Instructions but

90% of the time they don't understand. The thing for the E.R. is education before they get here. We have different syndromes, for example, the football phenomenon -- it's quiet when the game is on; when it's over they come to the E.R. A lot of Blacks and Chicanos know the system -- abuse it -- Medicaid patients are repeat types. A lot of patients we get to know by their first name; they call an ambulance for a sore throat. They don't want to pay \$10.00 for a taxi -- the ambulance costs the government \$85.00. The majority of Blacks and Chicanos are fairly demanding with minor things. They demand care immediately. The doctors and nurses get angry and frustrated with them. They come in at 3:00 a.m. with a cold. Our largest majority of patients are Medicare/Medicaid. The Black population is right around the hospital; and the Chicanos are five miles away.

Another head nurse had these comments:

The other groups -- Blacks and Chicanos are scared stiff. You have to approach them differently. If they can't speak English, we get multilingual interpreters which makes a difference to the patient. Caring doesn't have to be different, but explanation has to be simpler and detailed. At night, some patients get called "turkeys". Some "turkeys" are really sick. But at 2:00 a.m., it's not the time to come to the E.R. They are still patients -- human beings. They are frightened. We've got to look at all the elements. Nurses won't attend to needs as thoroughly or compassionately especially on a busy day. The E.R. has its own repeaters. There are so many lonesome people so they come where there are people. The public needs to be educated where the money goes in a hospital.

A licensed practical nurse expressed her thoughts about the Emergency Department:

As an LPN you are degraded. People don't have confidence in a LPN even though you may be better than a lot of R.N.'s. In the E.R. the attitudes have changed. I get the attitudes from the nurses. They get irritated if someone comes in with a sore throat over four days; or mothers with

children because they aren't real emergencies. But, maybe, the mother or person doesn't know what to do. If they did more teaching, maybe they wouldn't get so many back. If the patient doesn't speak English, the nurse asks me to care for him. It's fairly easy to get a Spanish interpreter in the hospital. At night, E.R. nursing is different -- nurses and others are hostile, more aggressive and not diplomatic. Patients are tired of waiting for everything -- doctors and lab. I feel like I am losing my "caring" since I came here. It bothers me.

The emergency department has become a place for government-dependent culture groups to find care. Cultural care was linked in a negative way to the social class of poverty and culture-specific care actually became stereotypical-specific care which mutually violated human dignity rather than protected it. Strangers sought a refuge from illness or loneliness and only found it again through rejection. Negative reactions followed. An Hispanic nurse said that at St. Jude's Hospital, a nurse did not understand anything about caring for people of other cultures. "Perhaps", she remarked, "the nurse would deal only with the language problem by trying to find an interpreter, but the rest, specifically the beliefs about life and family would only be criticized." Such was the case with the emergency room "cultural care". The majority of Hispanics and Blacks were looked upon as government-dependent repeaters who abused the system and demanded more than they deserved.

The trends toward examining care in terms of legal,

political, and economic factors demonstrated the current changing times. These were the realities. How nurses and administrators direct the decisions about these structural elements of caring will in fact decide the future.

### Admission Department

The Admission Department was a place where fear and anxiety usually operated at a very high level. People, who sought answers to personal and financial questions were greeted in different ways by many clerks. One of the clerks from the religious order looked upon her role with clients as one of caring with a religious dimension. She believed that "non-caring" attitudes existed between clients and employees. On the one side, she said some clients, especially those receiving Medicaid, took advantage of the system in the emergency room and this behavior evoked negative and unsympathetic responses from both admission and emergency room personnel. She continued with these remarks:

You have to deal with patients no matter what their attitudes are. I read into them. Men are frightened to death. They hate to be sick and in the hospital. Women are more patient. I read into their anxieties. I visit them in their room because I know they need someone. I don't just type their papers. I try to make them feel someone has sympathy for them. I grew up in poverty. We grew up to be proud of poverty. There must be a willingness to give up and help.

Economic, political, social-cultural and religious dimensions comprised interactive caring relationships in this department. Again, the decisions about how those dimensions are used will affect the lives of those involved.

### Intensive Care Unit

The social network of the Intensive Care Unit revolved primarily around technology for the purposes of saving lives. The unit was designed to support clients who needed technological intervention and consequently, the social behavior of professionals was for the most part, an enactment of that goal. A nursing administrator remarked:

It's a different kind of nurse who chooses this area. It's fast paced, lots of action, and new equipment. The nurse is looking for new patients with new things. She's burning to know. The more machinery the patient has the more each nurse wants that particular patient. That's where the action is. If a physician says no "cor zero", and we're not hurting for beds, the nurse won't want the patient. She says, "I'd like that one over there with the respirator and the Swan." Sometimes it becomes a knock-down, drag-out fight who is going to get it. You have to be careful making out assignments -- last week Suzy\* had so and so; this week I better give "him" to Karen\*. You need to equalize some of the action.

I really get disgusted. Some of the basic, elementary every day care doesn't get done -- nail care, hair, oral care, the basic type things

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\*Fictitious names

that make people comfortable. It gets to me when I still find the patients grubby after 24 hours. But they are more detailed into physician-type order things. They are important but so are the nitty-gritty things. I look at myself, and what I hope to have. I put myself in their position. There they are, helpless.

Clients generally perceived themselves as "out of control" in the intensive care unit. Because of the nature of the illnesses, and surgeries (especially cardiac surgeries), the control was in the hands of nurses and physicians. Helplessness and victimization characterized their reactions. Only one client favored nurse-control. Predicated on the premise that the unit was set up for life-saving, nurses believed that control must be in their hands. Technology and medication were powerful methods to maintain this attitude. Two clients had these remarks:

The nurses are not sympathetic. They are in control. It is important for successful progress though. I think if a patient doesn't do well -- the nurses lose control. That happened to a friend of mine -- a nurse gave too much control to his wife and family. I think the nurse is the thread hanging on to your life. You must have faith in that person who has control over your life!

In the ICU, you are out of control. You aren't in charge. I want to be a little bit in charge. I wanted to feel useful. I was afraid of dying after my heart surgery. I'm still scared. The nurse didn't explain anything to me. That tube down your nose -- it did more damage than good. I dreaded it. It was unbearable. They never give you enough time to loosen things up so you can spit. They expect you to cough when they give you a treatment. If they let me bend over, I

could have coughed something up. My head was at 40 degrees. The nurse made me mad. I pushed her away. You have that tube on your mind every hour. I'm better now since I'm on the floor. It was the first surgery I had and it nearly killed me. I didn't like the feelings I had in the ICU. They don't seem to understand feeling -- they're interested in coughing and getting the stuff up. I'll never forget that experience. As a well man, if someone said they would stick a tube down me, I would slap him down. The nurse didn't comfort me -- only my wife.

A staff nurse retorted:

In an ICU there is limited control. Women do better than men. Young people are less tolerant of control. The less educated are more submissive -- out of fear. The poor culture overrides individual cultures because the poor aren't as vocal about their needs. I think nursing is more holistic -- but it is difficult in ICU because of the increased technical needs.

The nurse's statements elucidated the problem of control and submissiveness, especially with respect to women and other minorities within our culture. Although political care (in terms of power and control) were operant effective nursing research into male, female and other culture group responses to technology, illness, and surgical intervention as well as the nurse as a political actor require investigation.

Male clients were traumatized to a large extent by their inability or nurses' inability to give them some control over their lives. Assaults by invasive body techniques without the benefit of explanation, physiological response, and psychological readiness created



anger and resentment in clients. Also, threats to the underlying belief system of nursing as a helping relationship affected both clients and staff. A nurse mourned:

Nursing is coming close to a symbiotic relationship with medicine. At a Critical Care Association nursing meeting, I was floored to hear death referred to as a multi-system failure. Now that nurses are problem-oriented we see the patient only as a problem. It's depressing and hopeless.

She continued:

In the ICU, caring is divorced from the emotional aspects of caring. The tasks take over -- defibrillation, waking someone up for vital signs, tubes, and monitors. It doesn't give me a warm feeling. It makes me feel bad. The violent things are caring, but you need to put limits on them in terms of outcomes. We need non-violent caring -- allow the patient a normal course of dying. Sometimes the patients aren't even touched. Often invasive techniques give more comfort to the patient because they're touched.

A nurse expounded:

In an ICU, you tend to lose interpersonal relationships. If the alarm on the monitor goes off, you check the machine. You seldom even look or glance at the patient -- also even when you go in to the room to shut off the machine. If the rhythm and waveform are okay -- you say, the patient is fine. You seldom think about their anxiety. Do you see how you get caught up in the technical world?

The modern intensive care unit has become the area concentration of the health care institution for technology and scientific advancement. Technology was the pivotal point around which the process of care revolved.

The political behavior (power relationships) of nurses also became a strong factor in the perceptions of care within the intensive care unit.

Technology has been considered the new tool for information in our culture. How it and power relationships are caring instruments in a critical care unit poses a major challenge for the institutional community.

### Cardiac Laboratories

The heart units were developed to interpret cardiac problems through x-ray and electrocardiographic interventions. Both laboratories were equipped with modern technology. Both areas were supervised by non-nurse (allied) health professionals who articulated and demonstrated that in all situations the "patient" came first. For example, at a cardiac catheterization, one technician and a nurse effectively reassured, prepared and explained the pending procedures to a client, and they efficiently assisted the physician by their technological expertise. Observations showed that coordinated team work coupled with calmness and sensitivity resulted in a precise radiograph and a satisfied client.

There were differences in this unit which were different from anywhere else in the hospital. The author questioned the technician and nurse whether or not they could identify what these differences were. The nurse

responded:

In the laboratory, a nurse has a "day" job with weekends off. Patients are in and out quickly. There is no long term care. There is an accurate procedure. We work as a team and it is a pleasant atmosphere. There is a lot less stress--you have it for a short while and then its over. In the unit, you have to rotate, there are long term patients in what is supposed to be a short term unit. There is so much stress with the pressure and decisions you have to make. Those are some of the differences.

The electrocardiography assessment unit was much the same -- short term care; precise procedures; generally cooperative clients; and a pleasant atmosphere. The technician director reported that she tries to instill into others the importance of caring for the emotional as well as the technical needs of the client. She stated the following:

You can have the best technical equipment and output, but if you're not interested in the patient, you can't calm or put him at ease. The technical world is essential, but quality [care] has to do with the person himself.

A client commented:

I got the best care from the technicians. They were interested in me -- what happens to me. The nurses on the floor don't really care.

Technological caring research and research into the pre-conditions and conditions of clinical stress is needed to demonstrate why and how some advanced technological units create successful interpersonal environments and why some do not.

Oncological Unit

The Oncological Unit was viewed by many as a death ward. Clients frequently believed that shortly after admission, death would follow. Although hospital figures showed that a high percentage of clients return to productive living after initial treatments of cancer surgery, chemotherapy or radiation, the unit was a place where dealing with grief and loss, and preparation for death were normal activities. The chief concern of nurses was how the psyche influenced healing. Helping clients with decision-making and resolution of problems was a part of the clients' preparation for death. A critical factor in decision-making was giving control over to clients, and allowing them to experience total involvement in their stages of grief. Individualization became very important.

The unit was very small -- 10 beds. Intensive primary nursing was carried out to develop close personal relationships. A nurse commented that you know the patient, they know you, and anxiety levels both decrease. Another experienced Oncology nurse shared these thoughts:

I believe the individual personality is important in caring. If a nurse hates Oncology, the patient suffers. There are different types of nursing personalities for different types of care. I dislike "cardiacs" and "alcoholics." Cancer patients are calmer, more mellow, and appreciative. Caring is an intimate relationship -- a friendship. By sharing it

helps build a two-way trusting relationship. You gain strength from each other. A nurse needs to be needed. The patient can dump his stress on you, and by helping, you are getting positive strokes from the patient. You have to encourage the patient to work through his feelings -- he has a right to be angry. On the Oncology unit you give the control back to the patient -- they have choices; can make out their own care plans. On Oncology, you have to treat people as individuals. The Kubler-Ross Model\* is WASP -- a "perfect patient concept." It doesn't fit for Jews, Italians, or Chicanos. On this unit, you have to deal with your own fear of death and failure. Doctors fear failure because they are taught that to cut is to cure.

A young nurse expressed these beliefs:

Caring is responding spiritually, emotionally, and biologically in a certain way. There is a time to die. The involvement with the patient is critical. A nurse needs to be there; and she has to deal with separation after the patient dies. A nurse has to try to peel back all the social overlays and stigmas and hear what the patient is really saying to get at the patient's reality. She must use emotional and spiritual readiness to help the patient with the feelings of the finiteness of life, nearness of the end, and the transition of life to death. She needs to use intuition -- it is not spontaneous, but developed from a picture of the whole person -- voice, gestures, posture, family interaction, response to stress and pain, and communication of values. Nursing as it is now practiced has no chance for development of these values with the patient. We need to define really what we mean by care.

A licensed practical nurse had the following ideas:

Caring is being concerned enough to get involved with the patient. You have to develop a relationship -- a friendship and good rapport with

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\*A model of the grief process of dying clients

your patients. On Oncology, you are encouraged to get involved. It is a growing experience -- listening to the patient.

Nursing and all staff became involved with clients. A pharmacist pointed out that their changing role toward more effective, intimate patient and family contact was occurring on the oncology unit. The researcher observed that on the unit, goals of honesty, openness, and transparency significantly encouraged growth in those who were willing to take interpersonal risks in the helping process. The search for new meanings in caring relationships involved considerable struggle and extreme demands upon time and energy, but nurses felt that it was rewarding. "We love it." remarked a nurse. "We don't play games. It is okay to cry and get angry. We can sit down and talk. We can share in the patient's anger--it's okay to be mad at God, life itself, and it's okay to die. The patient can stop fighting."

Client reactions about caring varied. The researcher had long conversations with two people who were terminally ill. Here are their inner thoughts:

Care is sympathy, sharing, knowing how you like to be treated then treating others likewise. It takes compassion to be a good nurse. A lot of patients don't share because they don't trust doctors or nurses. Healing, even when dying, begins with trust. Some nurses are not nice. They yell at you if you have an accident and wet the bed. They get mad. If a nurse gets mad, she takes her feelings out on her patient. I've been in city hospitals for 31 years, and

I've seen nursing change. There is little feeling for the patient. It's just a job, something they have to do, something to get over with and go home. I can't tell the difference who takes care of me -- a R.N., aide, or L.P.N. All I care about is if they are good to me. I'll do everything in my power for them. I can see whether there is genuineness in their faces. Even though I'm dying, I know everything will turn out alright. Care is the love of God also. If you don't love God, you can't give it to others. Some people stray too far from the cross of Christ to understand suffering. You learn through suffering.

Caring is loving God's child. You can't help but love one of his children. You have to give what you would like to receive if you were ill. It makes no difference what religion you are. I'm Jewish. A patient feels if a nurse is feeling and loving. A nurse should not stay in nursing if she doesn't love it. Nursing isn't like it used to be.

These sensitive remarks can lead to an increasing awareness of perceptions of "authentic" caring. Comments, such as, "I can't tell the difference who takes care of me. . ." coincided with what Roger's (1961) wrote about therapists whereby he stated that the therapists' attitudes and feelings were more important than were his theoretical orientations, and the way in which these attitudes were perceived makes the difference in client responses to therapy.

The oncological unit typified the center for seeking personal meaning and human relatedness as an occupational goal despite some comments from the clients. With the advances in health care technology, the process of

dying has been promoted in the recent past. Kubler-Ross' structural framework of the stages of grief within the dying process has helped health care professionals and citizens deal with the concept of death (although cross-cultural research is indicated). This concentration, especially relating to cancer victims, has prompted dialogue in churches, universities, and the media. It also has led to the development of death preparation care in some institutions, and to the isolation of specific clinical units dedicated to the care of cancer clients, like St. Jude's Hospital. Although dying in the hospitals was as much a part of institutional life as the provision of medical or nursing care, clients who were dying with other than cancer did not receive the same "caring" benefits. Fostering special care for the dying in other units generally became the role of the Pastoral Care Department. Death-related intimate helping relationships were not divided proportionately. Thus, the quality of interpersonal caring differed significantly within the social system of the hospital.

#### Surgery (Operating Room)

In nursing's recent past, the surgical or operating room unit was thought to be technical or skill-related, not professionally oriented. Consequently, there was a lack of surgery-related educational promotion for



professional nurses, and a movement toward specialized operating room technician education. On the one hand, at St. Jude's Hospital, certified technicians made up a large percentage of the staff, and were involved in direct surgical procedures ("scrubbing" -- or assisting the doctor by passing instruments during the course of an operation). On the other hand, registered nurses continued to be active professionally in operating room care but they concentrated their efforts on coordination and management of activities during the surgical procedures

Clients were semi-conscious or asleep when they arrived in surgery which limited communication. A nurse commented that despite all the push for questioning physicians, clients still do not speak up and ask questions of their physicians adequately enough prior to surgery. She said:

They sign their informed consent. They have access to the Patient's Bill of Rights. They watch TV; but they still say to their doctors, "Anything you say." But, when things go wrong, they want to sue for malpractice. Then the doctors say, "I'm not God."

The primary role for registered nurses in the operating room was that of a "patient advocate", or "patient representative". A nurse administrator commented:

We are patient advocates because they can't speak for their own needs. We are responsible for what goes on in a room -- responsible for

the patient -- the whole patient; and the activities in that room. This is a critical care area, and when educators say it is only technical it makes me mad. We need to develop better pre- and post-educational programs for the patients so they are aware of informed consent. Doctors don't tell patients what they need to know. Our association is developing goals and standards of practice. Now educators are coming to us for post-graduate education course information in O.R. nursing. For years, the university insulted us, now they see the need.

In addition to the legal role, the business role was growing. A nurse expressed her frustration with the following:

Nursing is not run like a business, and this is a business. I have to estimate hospital costs now for over 200 procedures. They expect you to become an accountant, lawyer, administrator with no background. But even if I had the money to go back to school, I'd never spend five years of my life to get \$10,000 - \$14,000 per year. They are crazy if they expect people to do it.

Legal and business (political-economic) caring were the major components of professional nursing within the operating room, and nurses clearly demonstrated reasons for the maintenance of professional nursing in surgery. The conflicts between traditional and contemporary role expectations and goals call for new approaches to patterns of decision making for surgical professional nurses.

#### Recovery Room

The recovery room was the place where the client began to face the new reality of pain, physical or

emotional loss, and fear. Caring networks were aligned closely to physicians in observations of the clients' immediate post-operative course. "Most of the time we think of the body parts, like the brain or the lungs or the heart, rather than people", commented one nurse. "There is no 'caring', no personal relationship with a body part. Patients are helpless in here" she said, and continued:

It's easy for patients to be treated like cattle -- line them up like an assembly line. The body is broken up in parts from head to toe. When you check the blood pressure, you think of whether it's up or down, not the person. Surgeons think like that even more so. They only see what they are trained to see, for example, a urologist will only see the bladder.

With unconscious patients, you lose your ability to touch. When they are awake, you tend to treat them all as if they were unconscious. A nurse has to make a special effort to change. If the head nurse has an assembly line attitude, the rest of the staff do too. If she is kind, they pick that up. She is the role model.

The nurses assumed primarily political and technical roles in the Recovery Room. One nurse reported (and with disgust), the following:

There is a power struggle between the doctor and the nurse -- "I am the doctor, you are only the nurse." As a young nurse, you want teamwork. But the nurse is still the buffer. Nursing here is a serious game. There are tricks to it -- to get what you want for the patient. It is personally insulting, and you wouldn't use those techniques in another corporate setting. The diplomacy does get me what I want for the

patient's welfare. To me, it's subservient, and a "fetch" handmaiden. I am embarrassed to be a nurse. Here I play a manipulative role. What I really desire is to be an autonomous, assertive woman. It's really disgusting.

While some nurses told of their negative "political middlewoman" role, the researcher observed that younger physicians showed sincere concern for clients and nurses.

The image of the physician as a "god-like" person was not felt in any area as much as in the perioperative suite. Change toward positive nurse-physician relationships continues to be slow. There is a call for, however, more interdisciplinary education on the contemporary role of the woman-nurse. A new kind of "political caring" must be encouraged to promote truly "professional" interaction.

### Surgical Unit

Caring relationships of a surgical unit primarily operated within intra-inter hierarchical frameworks of nursing/physician leadership, and organizational management system wherein certain professional goals and values were shared. Physicians occupied the top position of the inter-hierarchical (organizational) model, but essentially were outsiders because they were non-employees. They directed their decisions, however, to head nurses and charge nurses who filled the top positions of the intra-hierarchical (nurse) model. Registered team

nurses, licensed practical nurses and aides (frequently minorities) occupied the lower portion of the hierarchy, engaging in direct client care. Physical and respiratory therapists, and other support personnel functioned interdependently when physician orders so deemed. Usually, the head and charge nurses set the tone for the overall organizational management of their clinical nursing practice. Under this system power was centralized. Perrow (1979) asserted that the principle of hierarchical ordering of office and authority says that "for every person there shall be one person above her to whom she primarily reports and from whom she primarily receives direction" (p. 30). Team management was designed for efficiency of time, money, and personnel, but efficient management on the unit failed to realize its total goals.

This unit was large, about 52 beds. Clients had numerous surgical, orthopedic, neurologic, and ophthalmologic problems; and there were many elderly. It was busy, but congregating in the utility room to talk was also a frequent pastime for nurses' aides. Team leading activities chiefly revolved around medications, and the delegation of duties.

One morning, an elderly man 85 years old was confused about his pills. He wanted to know what they were and when he should take them when he went home. The team

leader said he was senile. She remarked to the researcher that he asked about the pills every day (he took six at a time). She remarked, "You might not think this is caring, but I'm not hired or here to babysit. He's a senile patient -- sweet and nice, but he asks so many questions about meds, and I haven't got time to deal with him."

An old lady of 92 of East European ethnic descent, whose chart read that she was disoriented and confused, fretfully exclaimed that in the hospital she was treated like a "dog". She wanted to talk to her nephew about her finances but the team leader said she needed Valium.

In their moments of recreation, the staff talked about their frustrations with the shortness of staff, and now the increasing numbers of elderly people. An aide contended:

Care covers physical and emotional needs. Many people are dying. It brings you to where you need to confront your own death. A lot of nurses will avoid getting close to patients. You have to have feelings for them to get close to them. I can't handle death all the time. I'm concerned about the doctors and staff. They don't gear into patient's needs. We don't have any insertions on dying.

Another aide talked about the team:

The nurses won't help you. Some aides are hostile too -- even to each other. They don't like new people, and it affects care because they are hostile to patients. There needs to be more fairness -- a switching of heavy and light patients. Now that I work in this hospital,

I wouldn't want to come here. I don't trust the doctors -- sometimes they don't visit patients for days. I don't like some of the nurses either. No one talks to you.

An L.P.N. remarked that as a L.P.N. you are treated like you don't know a thing -- "treated like an aide or worse", she said. Also, there is no credit for good or back work here. There is a lack of supervision and leadership", she lamented. And, she continued:

R.N.'s are pill pushers. They are lazy. They won't empty a bed pan or help you. I feel like I'm a peon. I could do more. I take good care of my patients -- they are happy and clean. I give mouth, catheter and hair care. I think R.N.'s are in the wrong line of work.

Another L.P.N. retorted:

I can do everything the R.N. does except give I.V. meds. I don't feel I am treated very well.

Registered nurses did not share similar ideas, however.

One nurse spoke the following words:

People who care do the job. Patients feel that. It doesn't matter what education you have. People have come to expect a lot from professionals. Some non-professionals are just here for the job. Some aides and nurses are overwhelmed by the responsibility that they have. Those that care get through it. This is a good place to work. It is a self-satisfying position to deal with people who need help.

Lack of coordination, follow-up and management of clients' mobility and respiratory systems frustrated physiotherapists, and respiratory therapists. "The role of the nurse, as a coordinator of care, must be continually reinforced", stated one therapist (which he viewed

as the only role). However, when offices were closed, or therapists too busy, the nurses had to be, not only, the coordinators, but also the therapists.

Effective team nursing on this surgical unit was thwarted by problems of leadership, authority, responsibility; an elderly client population; the numbers, types, and tasks of workers; and interpersonal relationships. Conflicting views and behaviors of basic individual and managerial processes undermined the hierarchy. The managerial goals of control, efficiency and effectiveness failed to be realized significantly. As a consequence, the official goal of "working together" to accomplish caring tasks was replaced by a loosely organized system. People (including clients) who built their institutional lives around effective caring management desired better. Two clients expressed their dismay about the lack of continuity of care and personnel. The following are their comments:

I tell the nurses how to do my dressing because I have different ones every day, and some of them don't know how to do it.

I didn't receive my neck traction for a couple of days. No one seemed to know about the order. I want to go home where I have some control over my medication -- getting it on time is a problem here.

Political behavior was a dominant force on a unit which is controlled by a division of labor. But, what



was lacking was sufficient knowledge of the political process, and its relationship to caring.

### Medical Unit

The medical unit was enjoyed by some employees, and hated by others. Used as a "teaching" floor for residents, care was complex and often fragmented. Physician's orders were changed frequently because of teaching-learning situations, and clients (generally elderly) were subjected to constant change. Additional changes created tension for the staff.

The unit functioned under a team management system. The physician-learner model played a decisive role in how well the system functioned, and how effective the communication patterns were.

Working with the elderly was the greatest challenge for some staff on this unit. Nurses who were unable to cope ignored the aged, while others became involved. A nurse with many years experience stated:

You must be a good listener and observer. It is a person to person thing. Some people can't communicate so you have to squeeze their hands. You have to love them -- share each other's personality. The old people are lonely, starved for affection. They beg you to stay with them because often their families don't visit. It is unfortunate in nursing that we don't have time to give total care; to be close to patients. Sometimes when an old patient makes up his mind that no one cares, they will die -- literally starve themselves to death.

Loneliness became a vital factor in aged care. An elderly Hispanic woman talked about her feelings. She mourned:

My husband died since I've been in the hospital. I am sick -- kidneys, dialysis, and Parkinson's. I had a heart arrest in the intensive unit. I feel safe here. It's better here than anywhere else. I don't want to go to the nursing home. I want to have someone watch over me. I've had that here. I need to go where I'll be watched over.

An old Black man shared his feelings of loneliness and rejection:

I've been here a month. I like someone to pay attention to me, not pretending like they didn't hear me. Nurses are nice but they're human. Some nurses are nasty -- holler and scream when you mess the bed. I think my family is tired. They want to put me in a nursing home.

Caring for the sick elderly is a growing phenomenon in the hospital. Nurses who worked on the unit temporarily, dreaded their stay. Time was important. When clients needed to share, people couldn't be there to help. Their greatest need for people-sharing was lost to young physicians who tried their best to prescribe medications and procedures to alleviate their misery. And their misery remained.

This unit clearly demonstrated a need for interdisciplinary education on the total needs of the care of the aged. From a transcultural nursing point of view, the Black and Hispanic clients struggled with loneliness

and fear in much the same way as the Anglo clients. The Hispanic client did not feel the comfort of her family which traditionally was, and reported often in the literature as, a part of their care behavior. These changes elucidate the necessity of examining different cultural care models for the elderly rather than adopting only the traditional cultural kinship structural model.

#### Transitional Care Unit

After the development of intensive care units, the need for transitional care units for cardiac clients became necessary. The transitional unit at St. Jude's Hospital was designed to provide primary nursing (total client care) to ensure close surveillance and monitoring of clients' physical and emotional states. The unit operated at a high level of tension. Monitors flashed at the nursing station and each clients' electrical heart activity was recorded. Nurses attended to clients but often "machine tending" took a great deal of their time, activity, and energy. A young nurse reported:

Cardiac patients are different from people on oncology. Those people learn how to die. On our unit patients don't deal with death or fear the same way. A cardiac death is quick. Patients are anxious, not calm and serene. They are threatened and get out of control. They ask few questions, and often hand themselves over to you. We run their lives, and I don't know if this is what should be done for them.

I don't like primary care because I don't like

being alone with the patients. I like to share the work load with other nurses. It helps make a lighter attitude. You can laugh together and have fun. Also, in primary nursing, no one sees your "good" care. You get rewards when you work together.

The strain of caring for the seriously ill was evident. Lack of interpersonal support created a sense of isolation from one's peers which, to many nurses, was critical to coping with the care of the seriously ill. But, nurses also were attracted to primary nursing because they could be in close contact with clients, and they stated they could personally take control of procedures and tasks rather than delegate responsibility to others.

Most nurses expressed frustration over the fact that their workload (nurse-client ratio) increased when they received a wage increase. Clients were charged more for services in this unit because of the need for increased staff for closer observation and for monitoring expenses. Nurses reported that with the increase in client numbers, the emotional care to clients was reduced. The researcher observed that "ideal" primary nursing was not practiced (where the nurse in charge of the client [the primary nurse] and her associate were engaged in the development and change of nursing care plans according to the changing status of the client).

Patterns of communication varied. Communication

patterns were traditional, relating mainly to medical problems, and the investigator observed that nurse-physician interaction was active. Nurses were freer to make nursing decisions without physician approval. Flexibility for decisions about particular routine care patterns was initiated. A nurse-administrator remarked, however, that doctors continued to treat nurses as children. She commented:

They yell and insult you if something goes wrong. Nurses are still abused, and it causes embarrassment.

The changing role of the nurse included budget considerations. It posed a special problem for one administrative nurse who emphasized that responsibility without control was a continual frustration. She expressed the following thoughts:

This budget business is difficult for me. I'd like to see the accountants come over here. I'd tell them to go in and care for the patients -- then we'd see how they would do without knowledge; and being in someone else's area. I don't have experience in accounting. They expect you to be an accountant. Budget item prices change over the year. You have to do the budget, then change it six months into the year. You have to account for items if they fall over the budget no matter what the cost.

The multicomplex roles of nurses as interactionists, accountants and technologists gave rise to increasing tensions within the bureaucratic social structure. Priorities for physician and organizational goals continued

to dominate, and demonstrate just how little bureaucratic power nurses have. To strive for a greater voice and more participation in the conditions that affect the lives of nurses must be a persistent objective for the profession and the institution.

Rehabilitation Units (Drug,  
Alcohol and Cardiac)

Rehabilitation units have developed to meet the changes in the social environment. St. Jude's Hospital has responded to the critical health care problems of our age: increases in alcohol, and drug use, and heart disease by setting up programs to promote health and re-adaptation for clients to family and society. The major goal of rehabilitation was to achieve what was necessary to care for the self. Clients were encouraged through helping relationships, counseling and physical and/or recreational therapies to take control of their lives. This process of helping clients to develop control and responsibility for one's life was the style of caring practiced in these units.

Drug and Alcohol. Clients addicted to drugs and alcohol went through a series of steps to achieve discipline over their problems. Detoxification under medical and nursing supervision was the first step. A team of physicians, nurses, (R.N.'s and L.P.N.'s), psychologists,

social workers, counselors, and recreation therapists then began to counsel, to teach, and to recreate. The program was designed using Alcoholics Anonymous principles to meet the needs of individuals and groups.

Time limits were set in increments of six to twelve weeks to ensure the relearning necessary to alter one's life style. Each person was treated as an individual. There were successes and failures. Success was determined to a large extent, not only by self-discipline, but also, by the support and love provided by health professionals, family and peers. Young people experienced difficulties because of peer pressure. More often than not, it was difficult for them to isolate themselves from others of their group who drank and took drugs. A licensed practical nurse remarked:

Kids start off innocently as "partying". Then they cross the line -- need more than they want. Sometimes that line gets easier all the time. They hang around people who are the same. Kids don't know when they hit their own bottom. It's not real to them yet. In many ways the addict goes through patterns of loss and grieving. There is a lot of blame and denial, then they must surrender. You have to love the kids and talk to them on their level -- reach them by letting them know that you care. You have to trust. There is a lot of manipulation, but you have to be on top of it to allow them to grow. I reinforce that you've got to hurt to grow, but it will pass. Kid's aren't willing to hurt, so often they deny, run, or start drinking. I give them the tools to understand sobriety.

A registered nurse indicated that in adult

counseling, they have to go back to the age when the client started to drink. She said:

Their emotional growth stops. We have to go back and pick up where they left off. They have so much self-hatred and are lonely people. They want love and gentleness. I have great empathy for patients. You learn alot about yourself there. Fulfillment comes with people: open, honest, trusting, loving.

On the units, individual cultural perspectives were not taken into full consideration, but a nurse reported that they do their best with the different groups. She reinforced the fact that "we accept them, and really care -- that is what matters -- a Black feels the same pain."

Drug and alcohol rehabilitation promoted efforts to work together for the benefit of clients. Humanism and egalitarianism amongst all staff members, including physicians, was a strong value. This style of caring reinforced mutual respect -- for both clients and health professionals.

Cardiac (and Related Problems). In cardiac rehabilitation, professionals worked closely with clients. The registered nurse spoke of how important knowing the "patient" was. She commented:

I hate team leading. You can't get close to the patient. You just push pills, and check treatments. You don't know what's going on with the patients. Primary nursing is the only way to go. The whole hospital should be like that.



Clients were encouraged to start their day by getting washed and dressed, and taking their place at a communal table for meals. Occupational therapists assisted people who required the relearning of personal care skills. Other self care programs, such as, feeding, to help foster independence and to build endurance and to conserve energy were emphasized. One day, a non-English speaking Cuban woman would not eat her food and wanted her neighbor to eat it. After an interpreter was called in, nurses discovered that she didn't want to eat because she recently fell; and in Cuba after a fall people do not eat immediately because "they may get a blood clot in their brain." After a period of time, she was re-examined and reassured, then she began to eat.

Physiotherapy was a great part of the rehabilitation program. Assessment of exercise ability began as soon as cardiac clients were transferred from the critical care unit. The physical therapy equipment was set up in the unit for easy access and monitoring of progress. The researcher observed a man from the Middle East, unable to speak English, who suffered a stroke. Physiotherapists spent time assisting him to strengthen his paralyzed limbs. They communicated with touch, through their eyes, and verbal praise. He responded by showing how well he could exercise. Physiotherapists and speech

therapists provided in depth, one to one attention, and this effort resulted in increased growth and development. Clients, although frustrated by the tremendous output of energy, worked harder under the staff's continual encouragement. The presence of the individual health team members and the constant availability of the nurses showed positive results. The physiotherapist said that cooperation and communication were the key. After the individual care by therapists was given, nurses saw that the treatment plans were carried out on a 24 hour basis. Nurses were the constant professionals in the lives of these clients.

Rehabilitation is a new form of nursing for most hospital nurses. Encouraging self-help and giving up control is a role reversal. For some nurses, it was difficult, and the staff stated that generally they requested other areas to practice. For others, though, this type of nursing was humane, and fulfilling.

### Pediatrics

The children's unit was small -- 10-20 beds. An administrator stated it was open for the purposes of offering pediatric learning experiences for the hospital residents. Much controversy surrounded its economic value, and in many ways, the neglectful-looking environment supported this view. Pediatric nurses were distressed at

the lack of material attention given to the area, and felt it was a personal and organizational loss. Generally, seriously-ill children were housed in a specialized, regional center. A nurse remarked that often the unit became a place for some parents who wanted a vacation to leave their children.

Nurses who liked children expressed affection for them and it was obvious by their rapport that a bond of trust had developed. A young nurse commented that children developed trust more quickly, and they forgave more readily, especially, after they have been "hurt" with injections. A young adolescent expressed the following ideas:

I've been in the hospital at least fifteen times, I've only had one bad experience with a nurse -- not a bad average. I trust nurses more than doctors -- they know you better. They are my friends. It's important nurses are there, and willing to take care of your needs.

The relationship that ensued between a child and caretaker (a nurse or an aide) was special. It exemplified the way a child reaches out, and a caretaker responds. When parents couldn't be with their sick child, it was usually the nurse who took their place; and as one young child said:

Being there and watching out for you -- that's what is important.

Obstetrics and Gynecology

Changes in institutional care in the last 15 years have been evident in the care of mothers [parents] and infants. Societal and scientific influences have changed patterns in pre- and post-natal education including a greater emphasis on family-centered care, human bonding between parents and infants, varied preparations for childbirth, new labor monitoring techniques, and the use of nurse-midwives. St. Jude's Hospital obstetrical unit, although small, employed these new approaches to childbirth and the care of parents and infants. More relaxed visiting rights for family members and friends had been initiated by the institution. An administrator commented that often it was the nurses themselves who resisted change because change interfered with routine patterns of care. These patterns were observed in the nursery where supplemental feedings still were given to breast feeding infants; and in the nurses' criticisms toward administration about the number of visitors allowed. The researcher witnessed the nurses' aggravation toward increased numbers of visitors with members of Black and Hispanic culture groups. "The hospital is not a place for all these people", stated one nurse.

Problems due to changes in the organizational social structure were pronounced in all the areas (nursery,

labor, and delivery, post-partum and gynecology). A nurse with 35 years experience reminisced:

In the past it was drummed into your head that nursing was for the love of humanity and God. Nursing was not for personal gain, but for personal satisfaction. Being concerned and compassionate and putting the patient's interest above your own was the goal. Today it's different. With the economic situation, you can't exist on the love of humanity. The hospital is now a big business with offices and all these directors. It's more negative than positive. The only positive influence which came from the new education was to care for the patient as a whole.

Labor and Delivery. The "whole person" approach was felt in the labor and delivery rooms. Emotional and family care was a major part of the care provided to clients. The nurse had more control and was responsible for the overall assessment of the client and partner or family member. Doctors depended on and respected the judgment of nurses.

An important component of caring in this area was the communication network of the nurse, the client and her partner. In observations, the nurses supported the client with breathing instructions, and relaxation techniques using touch, and the tone of the voice. A chief nurse reported.

Voice control is one of the most important things. You can keep the patient really relaxed if you talk all the way through labor with a special tone of voice.

Post Partum Unit. On the post-partum and gynecolo-

gic areas, nurses were disturbed by the way in which the organization and people had changed. A nurse lamented:

Big business is preying on the public's misfortune of being ill. Hospital costs are up. Big business comes in. Administrators have to show a profit. The hospital shouldn't show a profit. No one asks to be sick. It just happens. Also, people who get sick are angry. They don't have time to be sick and take out their frustrations on nurses. They go through the same process as a dying patient. It's important to give them a lot of support. Some nurses do better at it. The only way things will change is through education of the public to the problems of nursing within the hospital. We might get better support and cooperation. People want caring.

An obstetrical client illuminated the need for caring nurses. "What comes to mind is love", she said.

I have received loving and kind attention. After giving birth you need something special. I received it and I haven't felt depressed. During labor I would have gone nuts without someone there to talk to me, tell me what to do and calm me down, and help me get control. I am very impressed with nurses. They show concern for my baby -- really tender the way they handle her.

A gynecological client however, did not express the same trust. She was dismayed at the lack of answers to her questions and felt that she had to wait so long before her call light was answered. She said:

I get the feeling they are really short-staffed. I think they forget me back here. There's not a soul to come in. You wait two hours sometimes. I know there's a conflict in nursing. I wonder if administration or nursing is holding out on care. It scares me. I'd rather pay a little more and know someone is there. I don't know if they react against you if you complain. You might have to wait longer. Human nature, you

know.

In response to this client's concerns, nurses faulted staffing problems and the lack of administrative responsibility. One nurse believed that nursing now had ceased to be a profession and nurses only saw nursing as a job. "In that case", she remarked, "nursing becomes an impossible situation."

What was apparent in the obstetrical and gynecologic unit were the contradictions facing nursing, and its practice within the institutional setting. New technologies led nurses to learn improved methods of monitoring infants, while older methods of feeding still were practiced in the nursery. The complex organization was a business enterprise, but nurses were denied union development and participation. Standards of dress, and visiting routines were relaxed, but nurses disliked the larger family involvement in care. Clients had loving messages to present to nurses about their care, while others were fearful and hostile. And nursing was a profession or it was just a job. In many ways, all the issues of concern were represented in this clinical area.

### Summary

An analysis of caring relationships on each clinical unit was the subject of this chapter. Caring relationships were influenced by personal and professional

beliefs and values, and were influenced by individual and collective organizational objectives as well as recent social and philosophical trends. The social structural elements of the institutional culture played a large role in how caring was perceived, and how those perceptions were acted out.

In this study, clients perceived caring as a human to human process. They desired that it be acted out humanely, and in their best interests. Clients also were aware that some health professionals were not motivated by the ideology of "otherness", and emphasized how the nature of the "job" of nursing, for example, took priority over giving to others.

Nurses, on the other hand, saw themselves as "caring" people, but were more and more distressed by the problems of large-scale complex bureaucratic systems. The bureaucracy, thus had become embedded in belief systems and behavioral expressions reflected those beliefs.

Other health care personnel responded to caring in light of the primary objective of their role in the health care system. For example, a physiotherapist was oriented to provide support for the "physical structure" of the client, and to assist the client toward self-care goals. Respondents stated that the bureaucracy affected caring by limiting employee numbers which limited



time to put effective goals into practice.

Non-nurse administrators indirectly became a part of clinical caring networks. They became targets for "poor caring" or "non-caring" beliefs and practices. Thus, a dualistic (we/they) system of management (similar to unions versus management) rather than a unified system of management had resulted. The we/they phenomenon could be interpreted as contributing to frustration, alienation, and hopelessness.

As a result of the analysis of clinical caring data, the notion of caring as a process of differentiation within the institutional setting was discovered by the researcher. Within each unit, caring took on different meanings, and forms, and generally one or two characteristics were dominant. Thus, the model for clinical caring (with the primary emphasis on nursing) was differential.

The following chapter will outline this process of discovery which led to the development of the institutional cultural theme, and the development of theoretical frames of reference.

CHAPTER VI

TOWARD THEORETICAL FRAMES

OF REFERENCE

This chapter will deal with the generation of theoretical frames of reference of caring within the institutional setting of St. Jude's Hospital. The analysis will show how the process of cognitive and behavioral investigations into caring led to the discovery of both substantive and formal theoretical frames of reference. Data from the cognitive (classification system of Chapter III), and the organizational and clinical (Chapters IV and V) investigations of caring laid the foundation for the discovery of an institutional cultural theme of differential caring (substantive data leading to a substantive theoretical frame of reference). This process of discovery led further to the discovery of a formal theoretical frame of reference, bureaucratized caring (or the social structure of caring). The following is an explication of the foregoing process.

The Cultural Theme of Institutional  
Caring: A Substantive Theoretical  
Frame of Reference

Geertz (1973) emphasized that "behavior must be considered with some exactness, because it is through the flow of behavior -- or, more precisely, social action that cultural form finds articulation" (p. 17). By examining caring (social action) as it was articulated and practiced within each clinical unit at St. Jude's Hospital, the cultural theme of differential caring was discovered. Caring relationships were aimed at solving problems in the social and cultural milieu of the hospital, and they took on many forms and meanings. The caring data were abstracted and related to humanistic, social, religious and ethical categories while others were related to technological, legal, political, economic, and educational categories. It should be noted that these categories are concepts related to specific, orderly functions, ways of thinking or behaving, that have evolved in the systems of the universal knowledge of man (woman) within cultures. In the structural-functional tradition of anthropology, and sociology, Murphy (1971) pointed out that social structures can be described as interrelated aggregates of groupings and the activities appropriate to these groupings may be seen as their life

processes, the functioning of the structure. It must be noted, that superimposing a structural-functional approach on the data was not the intent of this research, however, the data (functions and meaning) themselves formed the basis from which various coherent structures took form. For the purposes of this research, the concept of social structure was defined as "the interrelated and interdependent systems of a society [the hospital] which determine how it functions with respect to certain major elements, namely: the political (including legal), economic, social (including kinship), educational, technical, religious [including humanistic and ethical] and cultural systems." (Leininger, 1978, p. 61).

The following were the definitions of the social structural terms into which elements of caring characteristics were placed:

Political is a term used to describe factors relating to the inter/intrahierarchical role functioning of the hospital, team nursing (or the division of labor), decision-making, patterns of communication, union activities, processes of negotiation, confrontation, external government and insurance company influences; power, sexual stratification, prestige, and privilege; and in general, the competition for scarce (human and material) resources.

Legal is a term used to describe factors relating to accountability, responsibility, rules and principles guiding behaviors under established norms; formal legal systems, such as, informed consent, client and professional rights, rights to privacy, the "Patients' Bill of Rights", malpractice and liability.

Economic is a term used to describe factors relating to money, the budget, insurance systems; and in general the allocation of scarce (human and material) resources.

Social is a term used to describe factors relating to communication, social interaction, interrelationships, involvement, intimacy with friends and family.

Educational is a term used to describe factors relating to information, teaching, and informal and formal educational programs, and the audio-visual media for the purposes of conveying information.

Technical is a term used to describe factors relating to the use of machinery, or non-human resources; and the skills necessary to operate such machinery.

Religious is a term used to describe factors relating to sacred matters (acts of faith; prayer, ritual), or acts of "brotherly" love.

Humanistic is a term used to describe factors relating to the potential for human growth and development by acts of compassion and concern.

Ethical is a term used to describe factors relating to "right" acting by either/or religious, legal and moral behavioral standards.

Participant observation clinical data from participants (generally nurses) found meaning in certain social structural terms. For example, technological data was dominant in the intensive care unit, while data relating to religion and humanism were dominant in the oncology unit. Table 9 is a representation by clinical units, of the dominant caring concepts and their relationship to

Table 9

Differential Caring: An  
Institutional Culture

Units	Dominant Concepts	Structural Characteristics
Admission Department	Involvement Financial Involvement	Sociopolitical <sup>a</sup> Economic Religious
Emergency Department	Technical Competence Malpractice Government Dependency	Technological/ Educational Political Economic
Intensive Care Unit	Technical Competency	Technological
Cardiac Laboratories	Technical Competency Involvement	Technological Humanistic Social <sup>b</sup>
Oncology	Involvement Intimacy	Educational Social Religious <sup>c</sup>
Surgery	Advocacy Interrelationships Technical Competency	Legal Sociopolitical Technological
Recovery Room	Interrelationships Technical Competency	Sociopolitical Technological
Surgical	Team (Intra/inter-hierarchical Functioning)	Sociopolitical Economic

Table 9 Continued

Units	Dominant Concepts	Structural Characteristics
Medical	Involvement (Elderly) Team (intra/inter- hierarchical Functioning)	Sociopolitical Political Economic Social
Transitional	Involvement Interrelation- ships Technical Compe- tency	Social Sociopolitical Economic Technological
Rehabilitation (Drug/Alcohol/ Cardiac)	Involvement Independence Egalitarianism	Social Educational Sociopolitical
Pediatrics	Safety Involvement Unit Maintenance	Legal Social Political
Obstetrics and Gynecology	Involvement Team (Intra/inter- hierarchical Functioning)	Social Political
Delivery Room	Technical Competency Teaching Involvement	Technological Educational Social

<sup>a</sup>Sociopolitical refers to both social and political dimensions

<sup>b</sup>Social also can include Humanistic

<sup>c</sup>Religious also can include Ethical.

various social structural characteristics. This table exemplifies that caring (by dominant concepts) is differentiated, and differential caring can be identified by a systematic pattern which forms a social structure or an institutional culture itself.

The social structure of institutional caring (or the culture of institutional caring) is an explicit illustration of the logical organization of clinical caring knowledge. It also illustrates that the science of transcultural nursing is oriented toward providing the methods to examine a whole cultural framework for the purposes of meaningful discovery.

In transcultural nursing, Leininger (1978) proposed that "desired caring and professional nursing practices can be predicted from the social structure features (economic, political, religious, etc. [technological, social, humanistic, educational, legal]) of a culture if carefully studied" (p. 46). The careful study of an institutional culture showed that economic, political, religious, (and so forth) structural features had a strong influence on the nature and meaning of caring. Whether or not the professional nursing practices were desirable in all cases could be questioned. Further investigation is necessary to determine if all types of institutions (comparisons with similar institutions,



different institutions, or international institutions) have similar caring cultures; and to determine whether or not relationships of caring and the institutional social structure is or should be desirable.

### Substantive and Formal

### Theoretical Frames of

### Reference

The comparison of cognitive caring differences and similarities among groups of people within the institution generated categories of caring knowledge (psychological, practical, interactional, and philosophical). They were distinct yet interrelated categories. Similarly at the clinical level, categories of caring practices were identified demonstrating that dominant clinical caring characteristics existed within the institution. They, too, were distinct, yet interrelated. As a result, a major hypothesis has emerged from the cognitive and experiential categories of ethnonursing data, and could be formulated as follows:

In a hospital, differential caring is an expression of beliefs and behaviors relating to competing technological, religious, political, legal, economic, humanistic, and social factors of the institutional and dominant American culture.

Cultural meaning systems of caring evolved from the systematic organization of caring categories and this development of differential caring formed the basis of

the substantive theoretical frame of reference. Glaser and Strauss (1967) stated that substantive theory was the useful beginning for integrating formal theory. The thesis of a cognitive and behavioral social structure of caring clearly demonstrated that caring generally thought to be humanistically, socially, or religiously oriented has been enlarged to include bureaucratic dimensions (political, economic, technological and legal). Given the fact that professional caring in Western cosmopolitan cultures is practiced primarily within bureaucratic systems (rational-legal frameworks), a formal theoretical frame of reference, the bureaucratization of caring, can be postulated. Figure 2 illustrates the theory of bureaucratized caring (social structure of caring). Glaser and Strauss (1967) stated that grounded theory must be applicable in and to daily situations. Because the formal theoretical frame of reference evolved from inductive efforts, and the development of a substantive theoretical frame of reference (differential caring), bureaucratic caring is an integral part of those working in the hospital institutional environment. Learning the full meaning, and interpretation of institutional caring as "bureaucratized caring" can assist and facilitate a clearer understanding toward more purposeful caring goals.

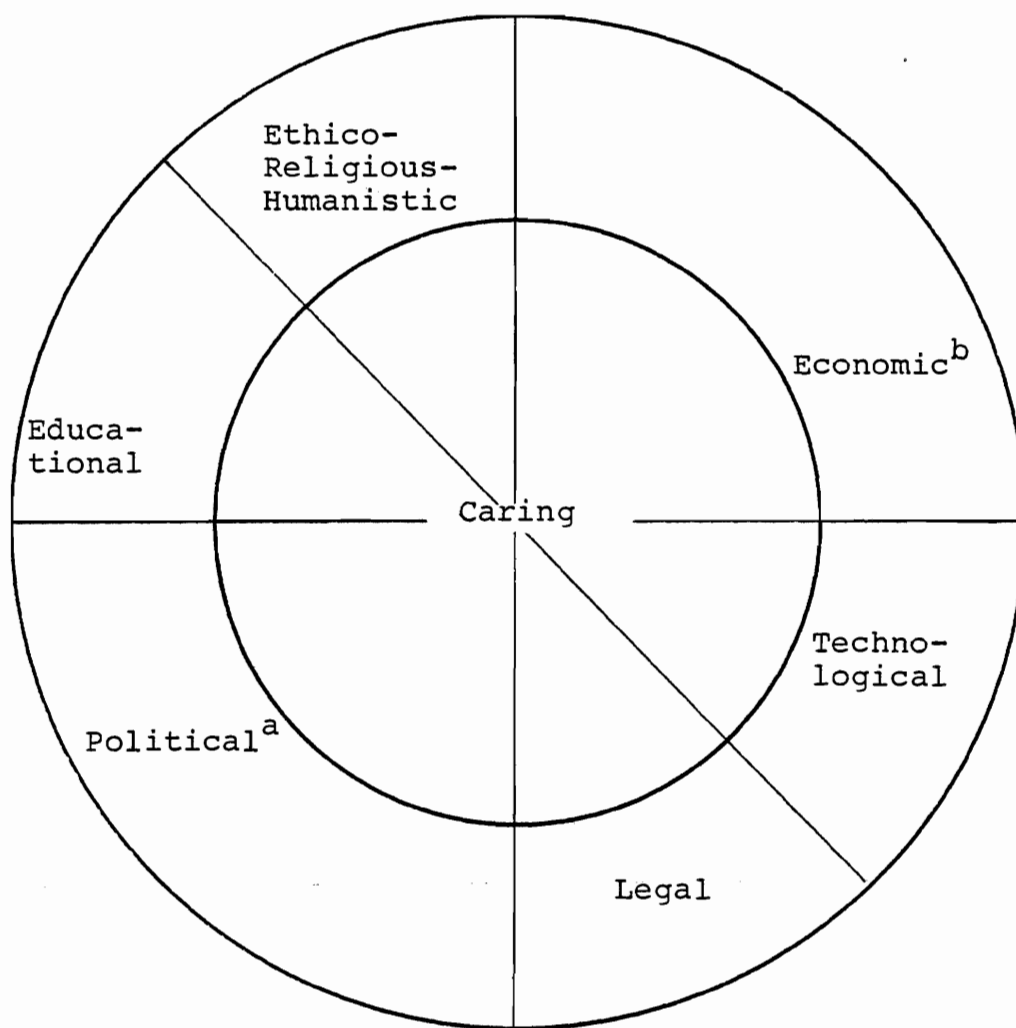


Figure 2  
Bureaucratized Caring (Social  
Structure of Caring)

<sup>a,b</sup> Note that the political and economic structures each occupy a larger dimension to illustrate their increasing influence on the nature of institutional caring.

Sovie (1978) wrote that nursing is experiencing the trends of a maturing profession. She identified the following concepts of maturation outlined by Schein: convergence, differentiation, and bureaucratization. When these maturational concepts are applied to the notion of the researcher's study of caring (claimed as the central focus of nursing [Leininger, 1977]) significant analogies can be made. First, caring is the convergent focus of professional nursing; second, caring is now highly differentiated by its cognitive and behavioral structures; and third, caring is now bureaucratized given the extent to which it shares a relationship to the bureaucratic social structure. Thus, discovering a formal theoretical frame of reference of the bureaucratization of caring is part of the historical process of the growth and development of the profession of nursing in particular, and the expansion of caring knowledge in general.

### Summary

This chapter outlined substantive and formal theoretical frames of reference of the transcultural nursing study of institutional caring. By analyzing perceptions and the flow of behavior within the administration and the clinical nursing units of the hospital; and from an analysis of the cognitive structure of caring, the

researcher identified a unique "culture" of caring. The central cultural theme of differential caring formed the substantive base which, when integrated, represented a relationship to the bureaucratic social structure. The formulation of substantive data into an integrated whole further led the researcher to discover and abstract a formal theoretical frame of reference: bureaucratized caring (the social structure of caring).

Historically nursing's values and behavior have reflected society's values and attitudes. Bevis (1978) identified four philosophical trends in nursing -- "asceticism, romanticism, pragmatism, and humanism" (p. 33). The most recent trend -- humanism in nursing focuses on the caring relationship as an interactional process. Ethnonursing data from this study, however, suggested that caring, perceived and practiced within the hospital, has been enlarged to include the influences of the bureaucratic social structural elements. In many ways, technological, political, economic and legal systems have displaced the more "humanistic" dimensions of caring challenging nurses and members of the institutional community to a greater understanding of the relationship between bureaucratization and caring knowledge.

Nursing has entered into a new philosophical trend, bureaucratization. It is crucial to our future profes-

sional life in complex societies. As Britan and Cohen (1980) profoundly accentuated, "The study of bureaucracies is, in effect the study of the most salient and powerful organizations of the contemporary world." Moreover, they asserted, "Like it or not humankind is being driven into a bureaucratized world. . ." (p. 27). Nursing's place in modern society will always be involved in one way or another with bureaucratic systems. What nursing does in relation to them will determine its survival in the ages to come. Perrow (1979) pointed out that "organizations are multi-purpose tools; there are a great many things we can do with them" (p. 13). The questions, and resolutions now are facing the profession.

The following chapter contains the discussion, implications, conclusions, and finally a list of recommendations which will further help in elucidating the meaning of the bureaucratization of caring.

## CHAPTER VII

### DISCUSSION, IMPLICATIONS

#### AND RECOMMENDATIONS

Today, much of social life is managed and controlled by formal organizations. Child rearing to the circumstances of old age are influenced by institutional structures. Perrow (1979) stated that bureaucracies not only satisfy and satiate us with their output of goods and services, but also shape our mentality, control our life changes, and define our humanity. Given their powerful influence in social life, bureaucracies are among the most important elements of contemporary culture. Knowledge of the cultural environment of the hospital, therefore, becomes imperative in understanding how nurses' and others' lives are defined, shaped and controlled.

In the field of transcultural nursing, Leininger (1978) emphasized the need for describing and documenting the basic phenomena that exist in the everyday world of nursing to facilitate new ways to develop knowledge

and practice. Basic to nursing and hospital systems is the phenomenon of caring. The purpose of the foregoing research was to discover and elucidate the meaning or meanings of this phenomenon in general, and to provide theoretical descriptions and recommendations for improving nursing education and practice in particular.

The final chapter is a discussion of the nature of caring within the insitutional setting, and its implications for nursing. A list of recommendations arising from the data analysis is presented.

### Discussion

The central domain of transcultural nursing is the study of cross-cultural caring behavior to determine the knowledge necessary to provide culture-specific and culture-universal nursing care practices. Leininger (1978) pointed out that the ideas and behaviors associated with caring are some of the least understood, and least studied of all human knowledge and research areas. To develop an understanding of cosmopolitan caring phenomena, and to provide an additional knowledge base for cross-cultural study, the author chose to research "caring" in the United States within the most primary type of caring institutions, the hospital, focusing on nursing. The use of the term, culture, was multi-dimensional in this study -- broad and global in the examination



of the dominant American cultural influences and values to a more specific use, relating to the meanings and symbols of the hospital, social interaction, and caring activities themselves.

For the goals of this study; definitions or meanings of caring expressions and behaviors; a classification system of caring; distinctions between the meaning of caring and curing; and the development of theoretical frames of reference, comparison through participant observation techniques was the methodology. The use and process of "comparison" was similar to methods developed by Glaser and Strauss (1967), that is, posing comparative data of small or large social units within the hospital clinical units and documents in order to discover conceptual categories of caring; and to generate grounded theoretical frames of reference of caring within the institutional setting.

In her analysis of the linguistic nature of caring, Gaut (1979) claimed that there was no clear-cut rule for the use of caring, but listed three general family of meanings or common usages related to the notion of caring: "(1) attention to or concern for; (2) responsibility for or providing for; and (3) regard, fondness, or attachment" (p. 8). Moreover, Gaut concluded that caring was a logical construct, and caring competency

involved an ordered series of intended caring actions to facilitate a goal.

The author's empirical evidence within the hospital based upon respondents' perceptions and behaviors demonstrated that the construct of care was not only logical, but complex. It involved a wide variety of meanings and numerous activities, actively and passively expressed and ordered, according to personal and/or professional ideologies, roles, and the hospital and dominant American social structures. The transactions between individual experience and institutional functioning documented the organizational structural influences on caring, and how caring was defined, interpreted and played out within a bureaucratic culture.

Thirteen hundred and sixty-two caring responses or definitions of the 192 participants in the semi-structured interviews within the hospital resulted in a taxonomy or a caring classification system. The responses were divided into four main dimensions with their respective subsets: Psychological (Cognitive and Affective); Interactional (Social and Physical); Practical (Technical and Social Organization); and Philosophical (Cultural, Ethical, and Spiritual). The dimension receiving the greatest number of responses was the Psychological, followed by the Practical, Interactional, and lastly the

Philosophical. The responses in order of frequency and meaning reflected the shift from the more philosophical-religious trend of a Catholic institution to trends oriented toward practical problems of the bureaucratic organizational framework.

A cognitive analysis of caring suggested that the institutional community was influenced by hierarchies of competing values. Clear distinctions relating to care and cure phenomena, important to the underlying development of transcultural nursing knowledge were not specifically differentiated. Meanings of cure (solution to medical problems by surgical, technological, or pharmacological interventions) were woven into the fabric of caring descriptors. Clients, however, could distinguish between care and cure. Their interpretations of caring primarily encompassed the ability of the nurse or health provider to treat them individually, and with compassion -- to understand and hold dear their vulnerability to losses of power and control over their own lives. Clients of different ethnic groups appreciated attention to communication and effective linguistic translations, but reiterated the need to be treated equitably and with compassion. Individual cultural food preferences were of little importance when there were compelling needs for friendship and freedom from loneliness

and dejection. Client perceptions of caring, therefore, were distinguishable from professionals. For clients, there was hope for a reciprocal consciousness between the self and others. For professionals, consciousness between the self and the social structure was developing. Because of the interdependence of the institutional community and the strong political, economic, social and technological character of the contemporary bureaucratic system, a change had occurred in the character of the ideology of caring. This shift represented the decisive social changes taking place in our time. The meaning of caring became a natural result of the interplay between individual experience and the mechanism of large-scale bureaucratic transactions.

Moving from the cognitive analysis to institutional and social relationship analysis, once more demonstrated that there was a logical connection which existed between the behavior and the social organization. Observations of people in their life ways at St. Jude's Hospital; at their work on clinical units, at meetings, or in written materials bore this out. Contrasting examples of differential caring patterns emerged. In the emergency department, for example, the legal concerns and the problems of government dependent clients were of paramount importance in caring descriptions. In contra-

distinction, in cancer work, nurses and others were concerned with humanistic and religious aspects of grief and dying. Critical care nursing adopted as its claim to caring, technology, while on the general-medical-surgical clinical units, political relationships relating to the division of labor in delivering care took precedence. On one unit, direct interactional behavior was a high value of both professionals and clients, while on another unit, tasks and direct interactional behaviors became the goal. In essence, each clinical unit developed dominant characteristics emerging from specific organizational and caring objectives, and values were incorporated into the aspects of caring beliefs and behavior. As a consequence, the social structure of caring could be identified. Although some characteristics were common to all units, differential characteristics were illuminated. Thus, the theme of caring within the institutional setting was differential, and in essence, caring was bureaucratized.

These theoretical frames of reference of differentiation and bureaucratization of caring (the influences of competing institutional economic, political, legal, ethico-religious/humanistic, social, educational, and technological forces) enlarged the meaning of the concept of caring from strictly humanistic and/or

religious/ascetic significances. The expansion of caring knowledge has importance for institutions but particularly for nursing. A critical paradox is emerging between the historical meaning of caring in nursing, and the current professed institutional caring ideologies. Traditionally, the nursing profession has been oriented to "otherness", that is, the interests of the client and the physician stood above those of the nurse. The bureaucracy with institutional and public goals, and the relative weakness of more humanistic goals has created the climate for the changing values and the development and implementation of goals related to the social structure itself. "Ideal" nursing models of care are being replaced by bureaucratic models which to a large degree have produced professional conflict and stress for the majority of nurses.

Major outcomes of stress have caused alterations in "humanistic" role behavior. The old value system was challenged by a generation of nurses who saw themselves as people seeking personal advancement and gain within the conditions of the hospital and the profession itself; or succumbing to feelings of alienation from the self, clients and others. Nursing was undermining its humanistic model of caring and was in conflict with itself and its descriptions of institutional models. In

essence, the ideology of nursing had changed. How did this change occur?

Bureaucratization has been gaining greater prominence in social development. The sociologist, Bell (1973) wrote the following:

In the period of late capitalism two major changes are central. Within the society, "the strength of specific capitalistic elements of economic life declines, while "mixed" public-private undertakings, state and communal public works and non-capitalistic economic endeavors "increase in number, size and importance." Within the firm, "there is a gradual decay of the entrepreneurial mentality." In place of the entrepreneur comes the bureaucratic mentality, and the firm itself becomes bureaucratized. (p. 65)

Furthermore, from his numerous analyses of the social structure, Weber (Bell, 1973) stated that "bureaucracy was identical with rational administration, and the class on which it was built, the clerical and managerial stratum in politics as well as in the economy" (p. 68). Weber predicted that the future belonged to the bureaucracy, not to the working class (Bell, 1973, p. 68).

Current sociological writings in the West have borne out Weber's predictions pointing to the idea of the bureaucratization of enterprise, and to society as a whole. (Bell, 1973, pp. 68-80). Moreover, the concept of bureaucratization as a world wide phenomenon has been supported by recent writings in political anthropology.

Britan and Cohen (1980) cogently stated the following:

Like it or not, humankind is being driven to a bureaucratic world whose forms and functions, whose authority and power, must be understood if they are ever to be even partially controlled (p. 27).

Given the dynamic process of increasing bureaucratization in world culture, bureaucratization and nursing require immediate attention. Presently, the consequences of this whole process are the gaps between perceptions within the institution about nursing and the modern world. The new idea of bureaucratization of caring as the nature of nursing in the social order is in conflict with the old order, directed mainly to one element in the nature of the social structure of caring, "humanism". Clearly, the continual struggle with the established administrative authorities in the hospital supported this view. The disagreements between the institutional expectations of nurses and nurses themselves revolved around the principle that nursing was, and must remain, static. When nurses attempted "controversial nursing", that is, the development of unionization to work out what they considered "just" negotiation, reproachment, not compromise, resulted. Nursing, too, has been weakened by inner discord and conflict. More and more, the institutional perception of nursing and nursing's "ideal" image of itself are essentially conservative and are inseparably linked to an out-dated world



view. The epistemological stance of nursing must contain a new conception of its place and function in society in general and organizations in particular. Nursing is not only a product of history, but must create history. A liberation from the old world view, or "demythologizing" of nursing is necessary. The idea of an order in institutional perceptions of nursing lives as the archetype. Many are expecting that such an order may come back. Witness the strong attachment to diploma schools of nursing. In a way, institutional nursing gets caught in a web of the past, having to wait until the future becomes the past before acting with it. Nursing's future as a profession depends on how well the synthetic nature of bureaucratic caring in its positive and growth-producing sense is understood. What are beneficial components of bureaucracy, and what are the epiphenomena capable of destroying the profession? As world society grows in complexity, the consciousness of nursing and institutional caring must also grow.

#### Implications

Bevis (1978) and Gaut (1979) have outlined the historical periods in nursing elaborating upon the ascetic, romantic, pragmatic and humanistic trends. Bevis wrote that "humanistic existentialism seems to be the natural maturational philosophy for nursing" (1978, p. 39).

Leininger (1977; 1978; 1980) emphasized the humanistic aspects of the profession, claiming the more humanistic dimensions of caring as the central ideology of nursing. However, this study has shown that the primary humanistic dimension of caring is rapidly being replaced, or expanded to other social structural dimensions. Humanism, once the pivotal point holding the structure of caring together, is unfolding to include other dimensions, such as, economics and politics, as the judge and the criteria of caring behaviors. The conflict between the humanistic criterion and modern social structural ambitions which, in the past, and still, though regarded with skepticism, has produced shifts in the meaning of caring. The former centers around the needs of human persons, the latter, though not totally disregarding human persons, is concerned also with the exchange of business activities and affairs of the social organization and society in general. Can they ever meet? The tension that exists between the humanistic needs and the material structure offers the greatest challenge to nursing. If bureaucratization is the new axial principle of world society (Bell, 1973), the development of awareness of the novel state of bureaucratic "caring" applicable to the needs of a more complex social order must be the center of professional determination and

assertiveness. The author adopts the view posed by Perrow (1979) that "bureaucracy is a form of organization superior to all others we know or can hope to afford in the near or middle future; the chances of doing away with it or changing it are probably non-existent in the West in this century" (p. 6). Therefore, it is particularly important that nurses understand and appreciate what is becoming predominant within complex organizations, and in advanced industrial societies. The implications for nursing can best be developed by highlighting some relevant factors about industrial society and humans in relation to nursing behavior.

Knowledge and organization characterize industrial society, and social/cultural frameworks are the structures that order the lives of individuals in the society. Bell (1973) asserted that "the development of bureaucracy has become the central problem for all societies, socialist or capitalist" (p. 80), and . . . "the desire for greater participation in the decision-making of organizations that control individual lives (schools, hospitals, business firms) and the increasing technical requirements of knowledge (professionalism, meritocracy) will form the axis of social conflict in the future" (p. 8). This social conflict manifesting itself as alienation has begun to occur for nurses within the

bureaucratic organization.

The ideas of conflict, struggle, and contradiction and alienation have been central to Marx's social-economic analysis of society. However, Britan and Cohen (1980) indicated the following:

While Marx was certainly right to sense the importance of alienation, he may have been wrong to tie it only to class struggle, not realizing that alienation could also be opposed by other socio-cultural factors that emerge to satisfy the needs created by bureaucratization of human life. (p. 26)

Although Marxism is not the full explanation of reality (Kuhn, 1976), nevertheless, his concern with, as well as the concern of Hegel (Baum, 1975) to objective, social and institutional factors in the creation of culture and consciousness currently are important to an analysis of institutional nursing, and the notion of the bureaucratization of caring.

Baum (1975) stated what characterized Marx was his exclusive preoccupation with economic and political structure, and the fact that man was changed not so much by new arguments as by transforming the social institutions in which he lived. Work, created by those in control of production, to Marx, was alienating. The worker found it impossible to be at home in his place of work -- It became not in any sense fulfilling but only a means of survival (Baum, 1975). In light of Marx's

descriptions of workers and the social political framework of institutions, analogies can be drawn to nurses involved with institutional caring. Forms of alienation are taking shape, that is, work as only survival leading to the burn-out phenomenon, hostility toward self, client, and the organizational management; revolution in nursing in the form of tendency toward unionization; and the exodus from and the lack of recruitment to nursing itself. Baum (1975) reported that in Marxist's words, alienation is not natural to human life: "alienation produced by labor is threefold, alienation from nature, from personal life, and human fellowship" (p. 26).

Marx's views of man's productive life were reflected in those of the philosopher, Hegel, in which Hegel analyzed alienating religion (bad religion) by stating that it divided the human family into rulers and ruled. Alienation, in Hegel's terms, referred to "the structures of separation which prevent people from enjoying their power, from living up to their destiny, and from participating in the unitive forces of love and truth operative in their midst." (Baum, 1975, p. 15). In contrast to Marx, Hegel's system postulated that every negation had a positive role, and out of human alienation was born a new form of reconciliation and unity (Baum, 1975, p. 32). According to Baum (1975), Marxism, the more

popular form of the analysis of alienation, had lost the positive dimension. In his study of social conflict, Coser (1956) supported the Hegalian view and asserted that "conflict within a group may help to establish unity or to re-establish unity and cohesion where it has been threatened by hostile and antagonistic feelings among members" (p. 51). Thus, from these analyses, forms of alienation are not negative, but have positive forms which are but phases of one process. They also can be analogous to Kubler-Ross' model (1969) of grief whereby psychological alienation assumes a positive role at the point of a person's struggle with himself, his desires, his God, in the steps toward "acceptance" in the process of dying. Therefore, transferring this knowledge to an analysis of nursing, this point of alienation is where critical decisions are made -- to burn-out, revolt, or drop-out, or to make use of the results of alienation to achieve higher levels of synthesis through the integration of awareness, knowledge, compassion and negotiation.

For nursing, the dialectic between the traditional thesis (humanistic caring) and the modern antithesis (bureaucratized caring) is at a point of reciprocal action for mediation, progressivism, and evolution to a superior form of caring. The broader nature and essence

of caring must be intellectually pursued in relation to a more complex, cosmopolitan social order. Caring is logically bound to the contemporary social structure, and when viewed and understood in that light, the bureaucratization of caring is unifying rather than totally alienating. The nature of bureaucratized caring must be influential to nursing's thought to assure nursing's cohesion and strengthen its will to survive in modern culture. Alienation is critical and a necessary condition for self-awareness. In terms of Weber's (Baum, 1975) and Bell's (1975) predictions of the expansion of world bureaucracy, and the anthropological predictions of a bureaucratized humankind (Britan & Cohen, 1980), the present and the future of nursing need not be further alienating. Nursing has to collaborate in a conscious way in completing the process already begun within its former levels of historical development. Reconciliation with reality, and unity, the result of a new synthesis can create more effective human and organizational cooperation by contracting the social structural elements of bureaucracy into effective political, legal, economic, social, ethico-religious/humanistic, educational and technological caring or, in short, effective bureaucratized caring. Only if the nurse is penetrated by this change will she/he really be able to

collaborate in the construction of nursing that is needed in progressive culture. It will enable nurses to become subjects rather than objects of their own history!

A danger exists in adopting a term from the general knowledge of the progress of social organization, but the concept of bureaucratized caring does typify the changes in the meaning of institutional caring in relation to modern culture. It is a construct, put together by means of contemporary social and cultural analysis, of the diverse changes in the nature of caring in the hospital organizational system, which when integrated or synthesized becomes coherent. When contrasted with the other nursing conceptual/philosophical trends, bureaucratized caring is a natural historical process. In descriptive terms, there are three components: in the professional component, it represents a major shift in the interpretation of caring as primarily humanistic, and expands the structure of caring to include social structural dimensions for decision-making; in the organizational component, it represents the pivotal point from which to mediate and resolve alienating factors of the political/economic/legal environment; in the educational component, it represents an evolutionary process of the epistemological basis of nursing in general and trans-



cultural nursing in particular. From these perspectives, nursing professionals and institutional administrators can step back and observe that the bureaucratization of caring is the rise of a new structure which needs principles for directing caring innovation and influencing institutional social policy. A new structure poses new problems for social management. The issues which emerge with new interpretations as to the meaning of institutional caring require that people encounter one another in a spirit of cooperation and unity to further identify the facets of the caring structure -- economic, legal, political, technological, social, educational, and ethico-religious/humanistic dimensions. Given this task, nurses and others are called to discover the ideal in the real in the construction of deeper levels of caring knowledge of contemporary institutional culture.

In conclusion, a transcultural nursing study of institutional caring leading to the development of a theoretical frame of reference (the analytical construct) of bureaucratized caring has been the thrust of this research. It identified a structure and a broader meaning to the nature of caring, and specified a new dimension which must be managed. The context for that management must be communal. Bureaucratic decisions no

longer can be made exclusively by and for physicians and for technological/economic ends, but must include persons, especially nurses who hold the key to the maintenance of the social structure. The crucial problem, therefore, is the nature of the values which will be the guiding principles within this expanded concept of the meaning of caring. Will economics preclude a communal politics as nurses of St. Jude's Hospital decree? The answers lie within competing groups.

### Recommendations

The following are a list of recommendations and/or questions relating to the theoretical frame of reference of bureaucratized caring listed under the headings of Education, Research and Practice.

#### Education and Research

1. Analysis of the multi-dimensional nature of nursing as a social process, and a thorough examination of the epistemology of contemporary caring phenomena.
2. Analysis of educational curricula to determine their effectiveness in understanding modern caring descriptions and caring actions.
3. Introduction of transcultural nursing concepts for the purposes of expanding the awareness and knowledge of various forms of cultural caring phenomena --

institutional, ethnic/cultural groups, and international systems of bureaucratic culture. As a principal function of transcultural nursing is the analysis and comparison of bureaucratic caring in foreign cultures.

4. Analysis of the relationship of the academic bureaucracy of education to the development of modern bureaucratic caring values.

5. Research into the forces of culture on research studies related to nursing phenomena.

6. Comparative analysis of institutions, e.g. public health agencies, other hospitals, and nursing homes where "caring behavior" is operant to determine the effectiveness of the author's theoretical frame of reference of bureaucratized caring.

7. Exploration into the ethical values/principles necessary to guide the new structure of caring. Do we stop at Marxism as the basis for institutional analysis or do we move forward to negotiation politics as an overarching principle of bureaucratic caring?

8. Research into the isolated components of the modern social structure of caring. What are the comprehensive natures of economic, political, legal, educational, technological, social, ethical/religious/humanistic caring? Are there models of individual structural caring components? How can these models effect change

to greater degrees of synthesis of caring knowledge.

9. Research into factors related to culture-specific/culture-universal care to determine the models available to improve care, for example, intra- and cross-cultural models for care of the aged, the dying, class structures within different cultural/ethnic groups.

### Practice

1. Employment of a researcher at the practice level to analyze ongoing bureaucratic caring phenomena.

2. Identification into goals, plans and commitment to understanding the bureaucratization of caring.

3. Administrative and worker interaction in the form of conferences to explore communal politics, negotiation techniques, unionization.

4. The development of seminars to exchange ideas, feelings, theories about caring.

5. Review of the administrative policies, and the roles of physician, nurses, other professionals, and administrators within the institution.

6. Examination into the politics of aging, and how caring is affected. Is technological caring the primary instrument of intervention with the aged? Are there alternative forms of caring?

7. Examination of the payment policy to nurses

with higher levels of education. Can there be a more just political/legal/economic caring?

8. Examination of the budgeting principles with the concepts of human relations.

9. Development of continuing education to respond to institutional cultural caring changes; and the development of systematized classes on the concepts of bureaucratic caring -- economic, political, legal, social, ethico-religious/humanistic, technological and educational caring.

10. Identification and introduction of ethnic group transcultural caring phenomena to principles of health and illness.

## APPENDIX A

### GLOSSARY

1. Caring is defined as a helping process involving interpersonal interaction.
2. Curing is defined as a procedural interaction for the purposes of supporting physician's orders.
3. Professional Nurse is a person who has completed a recognized program of study in a college, hospital, or university school of nursing with a license to practice as a registered nurse for the purposes of providing knowledgeable nursing and health care services to patients/clients. Nurses may be engaged in roles as practitioners or care-providers (preventative and/or restorative), educators, researchers, and administrators who contribute to the welfare of nurses, the institution, and the professions; or to the health of the care-recipients (patients/clients).
4. Staff nurses are nurses who are engaged in the delivery of health care services to patients in hospitals where their roles are specifically structured toward specialized tasks.
5. Head Nurse is a nurse functioning in a leadership position with responsibility for a group of nursing personnel (professional and non-professional) in direct service to the patient and in, the coordination of health services with the physician.
6. Team Leader is a nurse functioning in a leadership position with responsibility for a group of nursing personnel (professional and non-professional) in direct nursing service as a care-provider to the patient; and functions in a coordinating role of health care delivery with physicians and nursing administrators.

7. Chief Administrator of Nursing Care is a professional nurse engaged in supervisory and top management services to nurses and clients within the organizational structure of the hospital.
8. Licensed Practical Nurse is a person licensed to practice as an assistant to the registered nurse with educational preparation from a recognized course and is a team member involved in direct patient care services.
9. Nursing Supervisor is a person engaged in a supervisory and management position with responsibility for nursing personnel, and the institutional system organization.
10. Nursing in the broadest sense refers to a body of knowledge and specialized techniques and processes to help people with health-threatening problems or conditions. Nursing can be viewed as a helping service, preventative and restorative, which is concerned with the direct personalized care and treatment of people, and indirectly through advice, guidance, and supervision (Leininger, 1970, p. 29).
11. Transcultural Nursing is the area of nursing which focuses upon the comparative study and analysis of different cultures and subcultures with respect to nursing and health-illness caring practices, beliefs, and values with the goal of generating scientific and humanistic knowledge, and of using this knowledge to provide culture-specific and culture-universal nursing care practices (Leininger, 1978, p. 33).
12. Culture is a blueprint for human behavior and can be a significant determinant of human thought and action. (Leininger, 1978, p. 85).
13. Values are ideas formulating action commitments. The ideas are instigators of behavior within the individual, that is, values and motivation are linked, but rarely do they coincide completely (Kluckhohn, 1951).
14. Patient/Client/Care Recipient is defined, in general, as a person seeking and in need of the services of health care practitioners for the purposes of preventative, curing, and caring health care.
15. Hospital is defined as a complex, cultural organi-

zation/bureaucracy or institution where persons in need of specialized health care services for the purposes of diagnosis, surgery, medical, obstetrical care and/or disease curing, and professional nursing care are admitted and accommodated during the course of their illness. Hospitals have institutionalized norms of behavior and patterns which guide professional and non-professional personnel who are also guided by a variety of ideologies of their occupational groups.

16. Unit/Ward is defined as a designated area or space within the hospital where patients are accommodated for specific illnesses or diseases and are in need of the specialized services of health care practitioners.
17. Administrator is defined as a person assuming a professional administrative role within the hospital and who is associated with the management and decision-making of institutional economic and political resources.
18. Role refers to a specific, "functionally" significant, intrasocietal difference in activities of humans, such as activities being learned and inter-related in patterned ways (Sarkin, 1954, p. 225).
19. Role Behavior refers to the system of action and attitude responses inherent in role performance or "role enactment" (Sarkin, 1954, p. 232).
20. Social-cultural Context refers to macro and micro levels, that is, cultures and social institutions and behavior which have specific norms.
21. Ideology is a system of ideas which make empirical claims about the condition and direction of a profession.



## APPENDIX B

### INFORMATION TO NURSING

#### ADMINISTRATION

##### Memorandum

Marilyn Ray, R.N., M.S., M.A., a Doctor of Philosophy candidate in Transcultural Nursing from the University of Utah has requested permission to carry out nursing research in all units of this hospital. On September 12, 1979 she presented her proposal for research to the nursing administrators whereupon it received unanimous acceptance.

Ms. Ray's research involves the following objectives:

1. To compare nurses, nurse-administrators, and non-nurse administrators values, attitudes, beliefs, and practices about the "caring" phenomena in nursing.
2. To identify, describe, and define the meaning of caring in the institutional bureaucracy of the hospital.
3. To describe the structural characteristics (ideologies and practices) of a complex organization as they relate to nursing values and their consequences for nursing practice.
4. To determine a classification system of institutional care behaviors.
5. To describe how different cultural groups (Anglo-American, Hispanic, and Black) perceive care.
6. To develop a descriptive theory of institutional

nursing care.

### Methodology

The methods to be used by the researcher to accomplish the research objectives are the following:

1. Interaction with select administrative, nurse staff, patients (clients), and support personnel (e.g. social workers).
2. Participation and observation on hospital clinical units.
3. Semi-structured interviews (using the audio-tape recorder, and notes) with select administrators, nurses, physicians, patients, and support personnel (nutritionists, radiology technicians, etc.).
4. Review of select hospital policies, philosophies, and records to support research.
5. Attend select meetings (administrative and nurse).

### Ethical Considerations

1. Any hospital staff member and patient has the right to refuse to participate in the research, and withdraw at any time during the course of the study.
2. Judicious use of patients for participation in the research will be sought at all times. All participating patients will be given a full explanation of the purpose of the research. There is no risk involved in patient participation.
3. All data are confidential -- for use by the researcher and the researcher's committee members only (5-member Ph.D. committee).
4. All audio-tapes will be destroyed after the data are transcribed.
5. No names will be used. "Role names" will be changed if readily identifiable. Pseudonyms will be used to replace names and role names.

6. Data will be abstracted into general patterns, processes, and theories of institutional nursing care.

#### Benefits of the Study

1. To assist hospital administrators in understanding the components of institutional nursing care.
2. To add to the body of nursing knowledge, and especially nursing theory.
3. To understand the structural characteristics of a complex organization, and its relationship to the care practices of nurses, and the health-illness behaviors of patients.
4. To describe a contemporary, institutional culture in conjunction with bureaucratic and professional ideologies.
5. To allow the nurse-researcher to develop additional research skills, and to complete requirements for a Doctor of Philosophy degree in Transcultural Nursing.
6. To assist nurses in increasing their awareness of how their "care" behavior affects patients.

## APPENDIX C

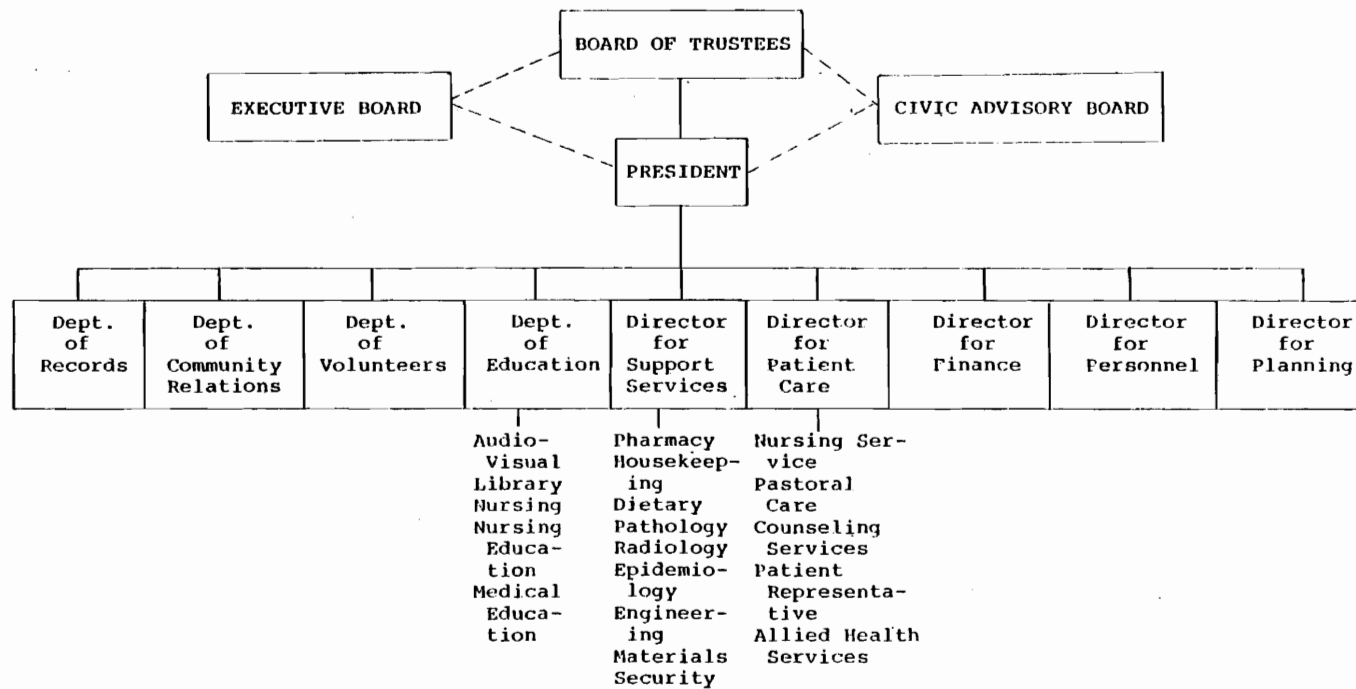
### GLOSSARY OF CARING TERMS

1. Cognitive Structural Analysis refers to the process of isolating distinct and related parts of the structure of caring.
2. Psychological is defined in relation to two caring components: a) Affective, which is relating to or arising from, or influencing feelings or emotions; expressing emotion, e.g. love; b) Cognitive is the knowledge used to define and interpret actions and events, e.g. decision.
3. Practical, in this study, is defined in relation to two caring components: a) Social Organization which includes the practical consideration and activities relating to the socio-culture structural elements of the organization, e.g. political, economic, legal; b) Technical refers to the subject matter organized in relation to techniques, principles and/or methods; or by way of technology to achieve a therapeutic purpose, e.g. skill.
4. Interactional is defined in relation to two caring components: a) Physical which refers to things relating to the body -- non-verbal communication, for the purposes of providing physical comfort, e.g. touch; b) Social which refers to interpersonal reciprocal action for the purposes of therapeutic outcomes, e.g. communication.
5. Philosophical is defined in relation to three caring components: a) Spiritual refers to a factor in the social life of respondents (expressed as caring related to matters of a sacred nature [relation of man/woman with God; prayer, virtuous or ritual acts]), which are seen in functional relationships to other social facts -- ethical, economic, judicial, political, and/or technological; b) Ethical refers to

connotations of morality, implications of what is right or wrong, professional and organizational principles, honor, or virtue, e.g. trust; c) Culture refers to perceptions, attitudes and knowledge of the caring needs of persons of different cultural/ethnic groups within the hospital.

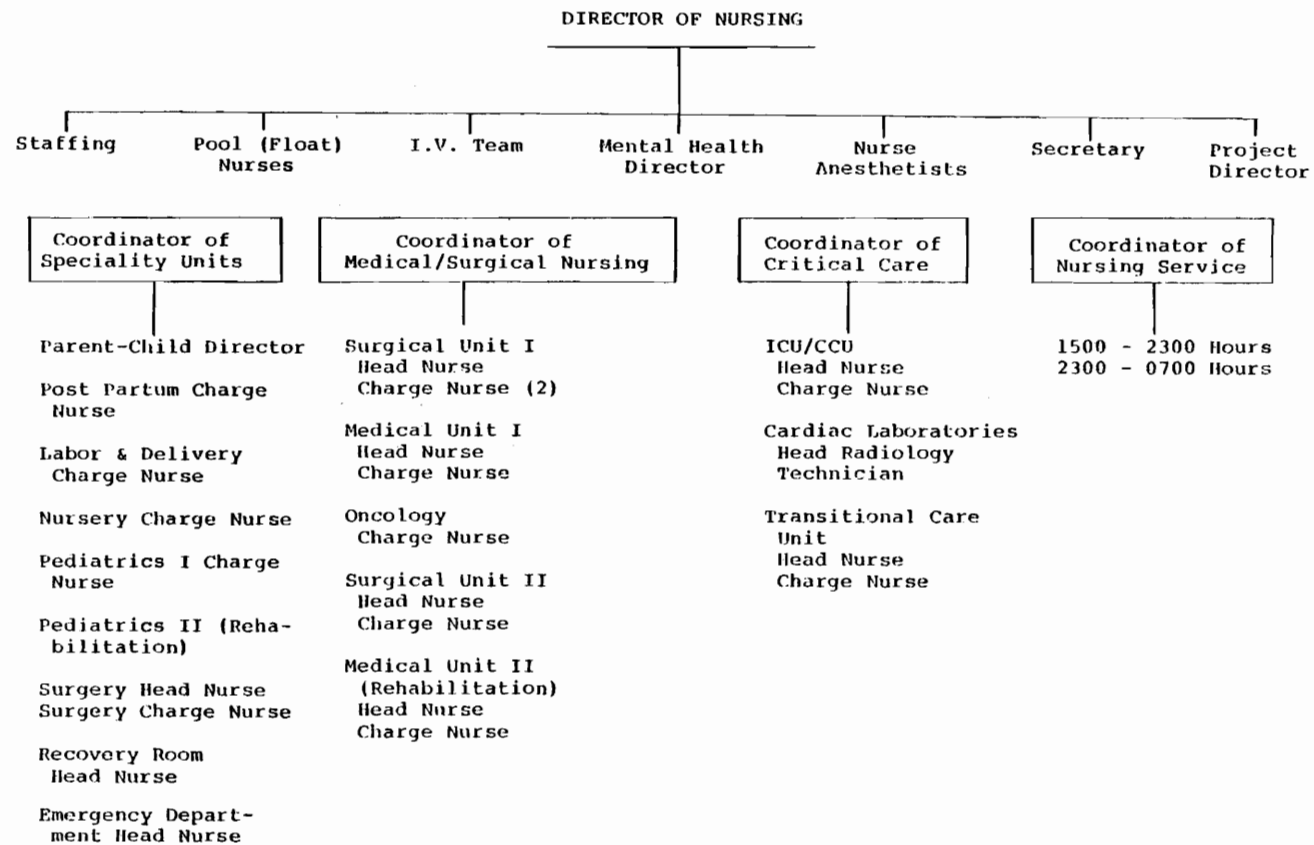
# APPENDIX D

## ORGANIZATIONAL CHART: ST. JUDE'S HOSPITAL



## APPENDIX E

### NURSING SERVICE ORGANIZATIONAL CHART: ST. JUDE'S HOSPITAL



## APPENDIX F

### STANDARDS OF ST. JUDE'S

#### HOSPITAL

PREAMBLE: St. Jude's is a response to the needs of others in genuine spirit of compassion, joy and Christian love which promotes wellness and wholeness of person.

We are committed to standards of care in our health care facilities which reflect this Christian manner of response to the community we serve: clients, personnel, visitors, physicians, and peers.

<u>STANDARDS</u>	<u>EVIDENCE</u>
1. Total bearing reflective of wellness.	a. Ready smile. b. Sense of humor. c. Positive manner. d. Neatness in appearance and in work. e. Composure under stress.
2. Alert and compassionate manner.	a. Sensitivity of others' feelings. b. Anticipating and responding promptly to others' needs. Assisting co-workers. Welcoming newcomers (patients, personnel and physicians), answering pt.'s light. c. Attendance as scheduled.



<u>STANDARDS</u>	<u>EVIDENCE</u>
3. Sharing of self (time and talents)	<ul style="list-style-type: none"> <li>a. Listening attitude.</li> <li>b. Sense of priority.</li> <li>c. Flexibility</li> <li>d. Willingness to change.</li> <li>e. Objectivity with empathy.</li> <li>f. Global view.</li> </ul>
4. Respect for individual's religious and cultural backgrounds.	<ul style="list-style-type: none"> <li>a. Understanding of response to crisis.</li> <li>b. Non-judgmental acceptance.</li> <li>c. Spiritual advisors (ministers, priests, and rabbis) are welcomed and encouraged to visit patients.</li> <li>d. Family encouraged to contribute in preparation for discharge or death.</li> </ul>
5. Mutual growth and communication of trust.	<ul style="list-style-type: none"> <li>a. Communication of trust.</li> <li>b. Generosity in sharing.</li> <li>c. Goal setting (direction).</li> <li>d. Patience in teaching.</li> <li>e. Recognition of limitation.</li> <li>f. Reasonable expectations.</li> <li>g. Firm kindness.</li> <li>h. Open and honest communication.</li> </ul>

#### Guidelines for Use of Standards

1. Tailor evidence to specific department.
2. Tailor this broad approach to specifics pertinent to the hospital.
3. Incorporate into orientation of new personnel.
4. Schedule periodic review and reinforcement of adherence to standards.

Mission of the Hospital

Highest possible care at the lowest cost.

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